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

WEDNESDAY, MAY 20, 2020
3:00 P.M.

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

<u>BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE</u>
Paul Yost, M.D., Chair
Dr. Nikan Khatibi
Alexander Nguyen, M.D.

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

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

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

The Board of Directors' Quality Assurance Committee Meeting Agenda and supporting documentation is available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, 8 a.m. – 5:00 p.m., Monday-Friday, and online at www.caloptima.org
Committee meeting audio is streamed live on the CalOptima website at www.caloptima.org.

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

1) **Listen to the live audio at +1 (415) 655-0052 Access Code: 992-100-417 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/3205133976462295055 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

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

CONSENT CALENDAR

1.   Approve Minutes of the February 19, 2020 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS

2.   Consider Recommending the Board of Directors' Approval of the 2019 CalOptima Utilization Management (UM) Program Evaluation and the 2020 CalOptima UM Program

INFORMATION ITEMS

3.   COVID-19 Impact on Quality and Population Health Management

4.   CalOptima Members Experiencing Homelessness Update

5.   Quarterly Reports to the Quality Assurance Committee
        a. Quality Improvement Committee Quarterly Report
        b. Member Trend Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

Webinar Instructions for Joining the Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee
May 20, 2020 at 3:00 p.m.

How to Join

1. **Please register for CalOptima Board of Directors' Quality Assurance Committee Meeting on May 20, 2020 3:00 PM PDT at:**

   https://attendee.gotowebinar.com/register/3205133976462295055

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

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:
   When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.
   --OR--
   TO USE YOUR TELEPHONE:
   If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.
   United States: +1 (415) 655-0052
   Access Code: 992-100-417
   Audio PIN: Shown after joining the webinar

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 19, 2020

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:00 p.m. Director Nguyen led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Alexander Nguyen M.D.

Members Absent: Dr. Nikan Khatibi

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel, Betsy Ha, Executive Director, Quality and Population Health Management; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

Chair Yost reordered the Agenda to hear Information Item 10. PACE Member Advisory Committee Update, and the Public Comments before the Consent Calendar.

INFORMATION ITEMS

10. PACE Member Advisory Committee Update
Elizabeth Lee, Director of PACE, provided an overview of the activities at the PACE Member Advisory Committee meeting held on January 2020.

PUBLIC COMMENTS
Patrick McGee, PACE Member Advisory Committee Member – Oral re: PACE gym/physical therapy equipment.

CONSENT CALENDAR

1. Approve the Minutes of the December 13, 2019 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee

> *Action:*   ***On motion of Chair Yost, seconded and carried, the Committee approved the Minutes of the December 13, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee. (Motion carried 2-0-0; Director Khatibi absent)***

REPORTS

2. Receive and File 2019 CalOptima Quality Improvement Program Evaluation
Betsy Ha, Executive Director, Quality and Population Health Management, reviewed the 2019
Quality Improvement Program Evaluation. Ms. Ha highlighted several accomplishments including
maintaining Commendable accreditation status from the National Committee for Quality Assurance
(NCQA), improving performance in 2019 on 42 of the 62 threshold HEDIS measures, and
implementing a comprehensive health network Pay for Value Performance Measurement Program.
Ms. Ha also reviewed several opportunities for improvement including achieving a 4.5 overall NCQA
Health Plan rating, implementing member and provider incentives for specific quality measures,
evaluating the effectiveness with HEDIS measures in 2020, and improving the exchange of hospital
data.

> *Action:*   ***On motion of Director Nguyen, seconded and carried, the Committee
> received and filed the 2019 CalOptima Quality Improvement Program
> Evaluation. (Motion carried 2-0-0; Director Khatibi absent)***

3. Consider Recommending Board of Directors' Approval of the CalOptima 2020 Quality
Improvement Program and 2020 Quality Improvement Work Plan
Ms. Ha presented proposed revisions to the 2020 Quality Improvement Program and the 2020 Quality
Improvement Work Plan. The recommended changes are designed to better review, analyze,
implement, and evaluate components of the QI Program and Work Plan. The changes are also
necessary to meet requirements of CalOptima's regulators, the Centers for Medicare & Medicaid
Services (CMS), and the Department of Health Care Services (DHCS), as well as NCQA
accreditation standards.

> *Action:*   ***On motion of Director Nguyen, seconded and carried, the Committee
> Recommended Board of Directors' Approval of the recommended revisions
> to the 2020 Quality Improvement Program and 2020 Quality Improvement
> Work Plan. (Motion carried 2-0-0; Director Khatibi absent)***

4. Receive and File 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality
Assessment and Performance Improvement (QAPI) Plan Evaluation
Miles Masatsugu, M.D., Medical Director PACE, reviewed the 2019 PACE Quality Assessment and
Performance Improvement Plan Evaluation. Dr. Masatsugu highlighted several 2019
accomplishments including successful DHCS Level of Care (LOC) audits, increased program growth
to 393 participants, of which 63 receive services at Alternative Care Setting (ACS) sites, completion
of three Quarterly Initiatives (Program Growth, Participant Care Plans, and Participant Triage). Dr.
Masatsugu also reviewed opportunities for improvement, which include: improving the quality of
care for participants, ensuring the safety of clinical care, and improving participant experience. Dr.
Masatsugu also mentioned that each year all areas continue to improve as the PACE analyzes the data
and addresses any deficiencies, which improves the outcomes.

> *Action:*   ***On motion of Director Nguyen, seconded and carried, the Committee
> received and filed the 2019 CalOptima Program of All-Inclusive Care for the
> Elderly (PACE) Quality Assessment and Performance Improvement (QAPI)
> Plan Evaluation. (Motion carried 2-0-0; Director Khatibi absent)***

5. Recommend Board of Directors' Approval of the 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Dr. Masatsugu reviewed the proposed 2020 PACE Quality Improvement Plan Description and PACE Quality Improvement Plan.

> **Action:** **On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of the 2020 CalOptima PACE Quality Improvement (QI) Plan. (Motion carried 2-0-0; Director Khatibi absent)**

6. Consider Recommending Board of Directors' Approval of Calendar Years 2020 and 2021 Health Network Medi-Cal Pay for Value Program Payment Methodology Incorporating the Health Network Quality Rating Methodology

Ms. Ha presented an overview of Calendar Years 2020 and 2021 Health Network Medi-Cal Pay for Value Program Payment Methodology.

> **Action:** **On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of CY 2020 and 2021 Health Network Medi-Cal Pay for Value (P4V) Program Payment Methodology incorporating the Health Network Quality Rating (HNQR) methodology for the Measurement Years effective January 1, 2020 Through December 31, 2021. (Motion carried 2-0-0; Director Khatibi absent)**

7. Consider Recommending Board of Directors Approval of Calendar Years 2020 and 2021 Health Network OneCare Connect Pay for Value Program Payment Methodology

Ms. Ha noted that there was no change in the methodology for the OneCare Connect program.

> **Action:** **On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of Calendar Years 2020 and 2021 Pay for Value Program for OneCare Connect Line of Business, which defines measures and allocations for performance and improvement for the Measurement Years (MY) effective January 1, 2020 through December 31, 2021. (Motion carried 2-0-0; Director Khatibi absent)**

8. Consider Recommending Board of Directors' Allocation of Intergovernmental Transfer (IGT) 9 Funds

Candice Gomez, Executive Director, Program Implementation, provided an update on the Allocation of IGT 9 Funds. It was noted that beginning with the IGT 8 through 10 these funds are counted as part of the capitation revenue CalOptima receives from the DHCS, so any expenditure of these IGT funds that do not qualify as medical expenses become part of CalOptima's Administrative Loss Ratio (ALR). Ms. Gomez reviewed the four primary focus areas: Member Access and Engagement – $6.5 million; Quality Performance - $3.4 million; Data Exchange and Support - $2.0 million, and Other Identified Priority Areas $33.1 million. Ms. Gomez also noted that the focus area of Other Identified Priority Areas includes support for the Whole Child Model (WCM) Program, which is projected to generate an operating loss of $31.1 million for FY 2019-20.

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

INFORMATION ITEMS

9. Improving Transitions of Care for Members Experiencing Homelessness
David Ramirez, M.D., Chief Medical Officer, provided an overview of CalOptima's efforts on improving transitions of care for members experiencing homelessness.

As noted at the top of the agenda Information Item 10 was heard prior to the Consent Calendar.

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

COMMITTEE MEMBER COMMENTS
Committee members thanked staff for their work in preparing for the committee meeting.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 4:02 p.m.

   /s/   Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 20, 2020

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 20, 2020
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item
2.   Consider Recommending the Board of Directors' Approval of the 2019 CalOptima Utilization
        Management (UM) Program Evaluation and the 2020 CalOptima UM Program

Contact
Tracy Hitzeman, RN, Executive Director Clinical Operations (714) 246-8400
David Ramirez, MD, Chief Medical Officer, (714) 246-8400

Recommended Action
Recommend Board of Directors' approval of the 2019 Utilization Management (UM) Program
Evaluation and the 2020 UM Program.

Background
Utilization Management activities are conducted to ensure that members' needs are always at the
forefront of any determination regarding care and services. The program is established and conducted as
part of CalOptima's purpose and mission to ensure the consistent delivery of medically necessary,
quality health care services. It provides for the delivery of care in a coordinated, comprehensive and
culturally competent manner. It also 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 the program encourage decisions that result in underutilization. Additionally, the Utilization
Management Program is conducted to ensure compliance with CalOptima's obligations to meet
contractual, regulatory and accreditation requirements.

CalOptima's Utilization Management Program ("the UM Program") must be reviewed and evaluated
annually by the Board of Directors. The UM Program defines the structure within which utilization
management activities are conducted, and establishes processes for systematically coordinating,
managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2020 UM Program Description to ensure that it is aligned to reflect
health network and strategic organizational changes. This will ensure that all regulatory and NCQA
accreditation standards are met in a consistent manner across the Medi-Cal, OneCare and OneCare
Connect programs.

Discussion

The 2020 Utilization Management Evaluation analyzes CalOptima's performance against 2019-
approved goals in two general areas: Operational Performance and Outcomes. CalOptima successfully
transitioned members eligible with the California Children's Services Program (CCS) to the Whole
Child Model (WCM) Program on July 1, 2019.

The 2020 Utilization Management Program is based on the Board-approved 2019 Utilization
Management Program and describes: (i) the scope of the program; (ii) the progam structure and services
provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and

CalOptima Board Action Agenda Referral
Consider Recommending the Board of Directors' Approval of the 2019
CalOptima Utilization Management (UM) Program Evaluation and the
2020 CalOptima UM Program
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(vi) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.
The revisions are summarized as follows:

1. Aligned program descriptions and committee references with the Quality Management Program and approved committee charter updates.
2. Updated CalOptima's Population Health Management strategy to include four key strategies: keeping members healthy, managing members through emerging risk, patient safety or outcomes across settings and managing multiple chronic conditions.
3. Added CalOptima's Health Homes Program and Homeless Health Initiatives to the UM Program including five components: behavioral health, health care, housing support services, community connections and public social services.
4. Added role of the Deputy Chief Medical Officer and updated the description of responsibilities for various key positions.

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

Fiscal Impact
There is no fiscal impact.

Concurrence
CalOptima Utilization Management Subcommittee

Attachments
1. CalOptima Annual Review 2019 UM Program Evaluation _2020 Description.
2. 2019 UM Program Evaluation FINAL DRAFT redline
3. 2019 UM Program Evaluation FINAL DRAFT clean
4. 2020 UM Program DRAFT FINAL redline
5. 2020 UM Program DRAFT FINAL clean

   /s/   Richard Sanchez   05/14/2020
Authorized Signature   **Date**

Annual Review: 2019 & 2020 UM Program

Quality Assurance Committee

May 20, 2020

Tracy Hitzeman, RN

Executive Director Clinical Services

2019 UM Program Evaluation

- Annual evaluation approved by UMC and QIC
  - ➢ Analyzes plan performance against 2019-approved goals in two general areas:
    - Operational Performance
    - Outcomes
  - ➢ Includes status of focused initiatives described in the 2019 UM Program Description
  - ➢ Informs areas of opportunity to address in 2020 UM Program

2020 UM Program Description

- Identify and include in 2020 UM Program:
  - ➢ Any changes in program structure
  - ➢ Those responsible for the UM program
  - ➢ Any new initiatives/programs, and
  - ➢ Any changes to the program scope and processes used to determine benefit coverage and medical necessity

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2019 UM Program Evaluation

- Accomplishments:

  - ➤ Successful transition on July 1, 2019 of CalOptima members eligible with the California Children's Services Program (CCS) to the Whole Child Model (WCM) Program.

  - ➤ Improved timeliness of COD expedited request processing, exceeding goal of 98% for all of 2019 for Medi-Cal and OneCare.

  - ➤ Maintained excellent timeliness of COD routine request processing, with an average of 99.95% within turn-around-times

2019 UM Program Evaluation

- Opportunities:

  ➤ Improve visibility of operational performance of direct and delegated Health Networks (HNs) operational performance as evidenced by transparency between the Audit and Oversight and UM Department audits and monitoring efforts.

  ➤ Strengthen monitoring and auditing functions through inter-rater education and identification of "best practices."

2020 UM Program Description

- The following slides are a summary of all substantive updates

Program Section	Change	Rationale for Change
Signature Page	Replaced Dr Federico with Dr Dajee	Current UMC Chair
Homeless Health Initiative	Added this program to the 2020 description. System of care developed to respond to the needs of the Orange County homeless. Includes five components: behavioral health; health care; housing support services; community connections; and public social services	New program as of 1/20/2020
Population Health Management (PHM)	Updated PHM strategy focus for CalOptima to include 4 key strategies: keeping members healthy; managing members though emerging risks; patient safety or outcomes across settings; and managing multiple chronic conditions	Reflect updated PHM strategy for 2021
UM Program Structure	Program structure summary updated to include specifics regarding our collaborative nature with our delegated partners, care and service providers; overview of reporting structure through the organization chart and committee structures; and ongoing nature of the evaluation of the program	Summarize the major components of the UM program structure.
Behavioral Health (BH) Services: OC/OCC	OC/OCC BH services managed by CalOptima effective 1/01/2020.	Important change of BH services now managed by CalOptima

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2020 UM Program Description (cont.)

Program Section	Change	Rationale for Change
Board of Directors	Added verbiage regarding the Ralph M Brown Act, that Board meetings are opened to the public. Also outlined that the Board of Directors' Quality Assurance Committee (QAC) role is to make recommendations to CalOptima's Board of Directors (BOD) regarding the Quality Improvement Program and outlined the Quadruple Aim, which was an expansion of the Triple Aim. Included several advisory committee's that ensure the provision of services with public input such as: Member Advisory Committee, OCC Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee. These advisory committee's report up to the CalOptima BOD and are open to the public	Identifies important advisory committees integral to CalOptima
Role of CalOptima Officers	Added role of the Deputy Chief Medical Officer in the UM program and plan, as well as description of responsibilities of the CEO/COO.	Ensure program reflected all staff involved in administration of the program

2020 UM Program Description (cont.)

Program Section	Change	Rationale for Change
Medical Director, Behavioral Health	Enhanced language to clarify the role in the QI and UM programs and the role of chair of Pharmacy & Therapeutics Committee	Ensure inclusion of all roles and responsibilities
Director, Utilization Management	Added verbiage that called out the roles of this position	Ensure inclusion of all roles and responsibilities
Behavioral Health Integration (BHI) Resources	Clarified roles in the BHI department to ensure each position reflects duties and job requirements. Included qualifications, training and supervisory responsibilities of appropriate roles	Ensure accurate identification of job duties and requirements per role
Committee Organization Structure Diagram	Removal of LTSS QI Subcommittee and Behavioral Health Quality QI Subcommittee. Removed explanations of each subcommittee below it, due to sunsetting	Subcommittees sunsetted and activities captured through UMC and Quality Improvement Committee (QIC) reporting

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2020 UM Program Description (cont.)

Program Section	Change	Rationale for Change
Integration with Other Processes	Important updates to demonstrate how UM integrates with other programs within CalOptima, as well as coordinates with and local community programs that take care of our members.	Collaboration internally and externally are critical for the success of CalOptima programs
Review and authorization of services	Updated the definition of medical necessity review, as well as specific updates to the Medi-Cal medical necessity reviews, MLTSS and members < 21 years old. Specific Medicare verbiage regarding medical necessity that is reasonable and necessary for diagnosis or treatment or to improve function	Critical to ensure the definition and requirements per LOB is accurate and clear
Behavioral Health Determinations	Information about the management of OC/OCC line of business (LOB) effective 1/1/2020. It included services such as prior auth review for covered services and those cases requiring authorization. Also indicated the criterion for making BHI medical necessity reviews such as MCG Health, Dual Plan Letters (DPL) and CalOptima policies	Important information regarding the management of these services brought in house 1/01/2020
UM Criteria	Updated the hierarchy of clinical decision making to include references to sources of criteria, in order, for each LOB	Specifics by LOB will help the reviewer understand the appropriate sequence in applying criteria

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2020 UM Program Description (cont.)

Program Section	Change	Rationale for Change
Practitioner and member access to criteria	Update to include provider annual training regarding UM processes and submission of referrals to CalOptima	Additional information on annual trainings provided to the network
Timeliness of UM Decisions	Updated Medi-Cal routine referrals to be completed within 5 working days of receipt of all information reasonably necessary to render a decision, but no longer than 14 days following receipt of request	Critical to be sure there is a thorough understanding of regulatory requirements on decision making time frames
Authorization for Post-Stabilization Services	Clarified that for Medi-Cal, a decision must be made within 30 minutes after receiving a Prior Authorization Request for Post-Stabilization Services (PSA) and all information reasonably necessary to render a decision; For OneCare or OneCare Connect, a decision must be made within 60 minutes after receiving such request and information.	Clarity on decision making requirements for PSA requests
Hospitalist/ SNFist program	Removed verbiage as CalOptima does not have a program at this time	Ensure accuracy of programs contained within the description

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CalOptima's Mission

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

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~~2018~~2019 CalOptima Utilization Management Program Evaluation
~~January 7, 2019~~

Executive Summary

The ~~2018~~2019 Utilization Management (UM) Program ~~and Work Plan~~ describes CalOptima's activities to promote optimum utilization of health care services for our members delivered in a high-quality, compassionate and cost-effective manner.

This evaluation of UM activity is completed annually and approved by the Utilization Management Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors.

There have been no changes to the overall UM program structure elements listed below during 2019. The program structure elements are:

- UM staff assigned activities;

- UM staff who have the authority to deny coverage;

- Involvement of a designated physician and a designated behavioral healthcare practitioner;

- The process for evaluating, approving and revising the UM program, and those responsible for each step;

- The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities; and

- The process for handling appeals and making appeal determinations.

Projects, Programs and Initiatives:

A. Utilization Management

In ~~2018~~2019, the UM department initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation. These projects included:

- Upgrades/enhancements to the Guiding ~~(GC)~~ Care (GC) Utilization Review Module in CalOptima's medical management system
- ~~Provider Data clean-up project – coordination with the Process Excellence department~~
- Desktop Procedures – cataloged, reviewed and updated
- ~~Added a UM Data Analyst to enhance monitoring and reporting activities~~
- Continued development of CalOptima Reporting Environment (CORE) to align operational reports with the data structure in GC and to continue to identify opportunities for process

improvement

- ~~Conducted an in-depth review of the California Children's Services Program and initiated groundwork for the transition to the Whole-Child Model~~Successful transition on July 1, 2019 of CalOptima members eligible with the California Children's Services Program (CCS) to the Whole Child Model (WCM) Program.
- Ensured all policies and procedures were in effect in accordance with regulatory requirements and accurately represent clinical operations processes~~.~~

The Medical Director of UM provides clinical oversight for the administration of the UM ~~Program~~Program and has been very engaged during 2019. He/s~~S~~he supports the UM process by ensuring that treatment requests are processed in accordance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluating the program's effectiveness against   established goals. For UM Program areas that do not meet the approved goals, modifications to program activities are proposed by leadership to the UM Workgroup (UMWG). As endorsed by the UMWG, the updated plan is presented and approved by the Utilization Management Committee (UMC). These changes are implemented by the UM Leadership and department staff. The UM Medical Director supports provider and member satisfaction efforts through the activities of the Benefit Management   Subcommittee (BMSC).   This subcommittee evaluates new and modified benefits   to determine the need for prior   authorization. He/s~~S~~he also chairs the bi-weekly UMWG, wh~~o~~ich provides input to the development and   processes of UM Program ~~and UM Work Plan~~ to ensure quality, cost efficient services~~,~~ and care are delivered to CalOptima members. The UM Medical Director led discussions with the nursing and physician group   in semiweekly concurrent review case rounds, discussing appropriate care guidelines, clinical and practical aspects of managing medically complex members in the acute and post-acute care settings and assisting with discharge planning management.   He also provided education to the team to ensure understanding of the clinical basis for decisions.

The UM Medical Director also provided focused education on specific topics including: genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, the Letter of Agreement (LOA) process, and evaluation of the appropriateness of one-day inpatient stays.

In 20182019, the UM Medical Director adequately supported the UM process and met the needs of the UM team through education, case review and availability.

B. Behavioral Health Integration

In 2019, CalOptima Effective January 1, 2018, CalOptima began to continued to manage all the administrative functions of Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima members, including UM, claims, provider network, credentialing, member services, care coordination, and Quality Improvement (QI.). In addition, on July 1, 2018, members 20 years of age and younger who were not diagnosed with an Autism Spectrum Disorder and were receiving BHT services through the Regional Center of Orange County (RCOC) began transitioning to CalOptima. The Behavioral Health Integration (BHI) department worked closely with other departments to ensure the provision of treatment was in accordance with mental health parity legislation and the prior authorization process complied with all federal, state, contractual, regulatory and accreditation guidelines. The Medi-Cal and BHT transition went smoothly with minimum possible disruption to our members.

For OneCare (OC) and OneCare Connect (OCC), Magellan Health served as CalOptima's Managed Behavioral Health Organization (MBHO) with the full spectrum of administrative responsibilities including UM, provider network, credentialing, customer service, inpatient services, and care coordination. BHI maintained a close working relationship with Health Network (HN) management, providing oversight of the MBHO's delivery of the mental health services and administrative functions.

The Behavioral Health Quality Improvement (BHQI) Subcommittee was held on a quarterly basis and reported to the Quality Improvement Committee (QIC). The BHQI trends, analyzes and identifies improvement areas for behavioral health (BH) services, ensures access to quality BH care, and enhances continuity and coordination between behavioral health and physical health care providers The BHQI is chaired by the BH Medical Director and is comprised of internal and external members, which include delegated health network participants, community partners, behavioral health practitioners, and the Orange County Mental Health Plan (MHP), administered by the Orange County Health Care Agency (OC HCA). The chair is responsible for leading and presenting subcommittee recommendations to the QIC. In addition, a BHQI workgroup met regularly throughout 20182019 for additional work and analysis on BH quality initiatives. This group served to address suggestions from the BHQI that assisted with strengthening interventions, data review and key areas for improving the member experience. In 20182019, the BH Medical Director provided critical support for establishing key BH processes of monitoring utilization. Utilization triggers were developed to identify potential over utilization and to determine if the mild to moderate benefit was an appropriate level of care for the member. of

~~monitoring utilization. Utilization triggers were developed to identify potential over utilization and to determine if the mild to moderate benefit was an appropriate level of care for the member.~~

C. UM Data Management

UM report design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Services (IS) department staff. Together with UM department subject matter experts, EA and IS maintained a focused effort to improve the understanding of key data standards to ensure reliable tracking and trending of metrics for both   CalOptima and the delegated health networks. Further refinement of data (XML) file format   ~~Decreased data lag was accomplished by implementation of a new (XML) file format~~ for health network submission of data elements including authorization information led to increased reliability of reports and improved the usefulness of information. Additional efforts are planned to leverage availability of this information to UM, Quality and Audit and Oversight (A&O) by configuring standard queries of the data mart.

~~In 2018, CalOptima migrated from MicroStrategy, a data analytics and visualization tool, to the Tableau platform which will enable advanced data analysis and reporting. The UM department also added a Data Analyst position that will assist in enhancing the quality of UM data and analysis.~~

D.   UM Delegated Provider Oversight

~~D.~~   -Medi-Cal

In ~~2018~~2019, oversight of the delegated HNs for UM was performed by CalOptima's Audit and Oversight (A&O) department.   Monthly, each HN was monitored by reviewing a sample of prior authorization referral files against the threshold of 98% for the following activities:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness:
The delegated HNs ~~performed~~ performance for timely decision making ranged from 88-99% for routine pre-service referrals and 86-99% for urgent pre-service referrals ~~well . for routine pre-service authorizations (98%). For expedited requests, the HNs, scoring 97%, had a negative variance to goal of 1%. One of the delegates encountered challenges in the first and second quarters with timeliness, but made marked improvement by the third and fourth quarters, following a corrective action plan~~ The established threshold for timeliness of clinical decision and notification is 98%. 90% of the health networks met threshold for routine pre-service referrals (10 of 11) and 81% (9 of 11) met the threshold for urgent pre-service referrals. CalOptima's A&O department issued corrective action plans (CAP) to the HNs for all performance less than the established threshold.

Clinical Decision Making
The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are approved, denied or modified. In ~~2018~~2019, the HN files ranged between ~~67~~56–100% compliance with the standard for urgent files reviewed. For routine files reviewed, compliance ranged from 64-100% ~~, representing an opportunity for continued focus in this~~

~~area.~~. Audit and Oversight reviews files on a regular basis and initiates CAPs for performance less than the established threshold.

Notifications

The delegated HNs are audited regularly ~~on~~ for compliance with regulatory standards related ~~member~~to member notification~~s~~ of denials (NOAs). In ~~2018~~2019, compliance ~~to~~ with the standard ranged from ~~74 -100%; this continues to be a focus for improvement.~~

64 -100% for urgent and 66-100% for routine HN referrals reviewed. Audit and Oversight reviews files on a regular basis and initiates CAPs for performance less than the established threshold.

20182019 CalOptima Utilization Management Program Evaluation

OCC

In 20182019, oversight of the delegated HNs for UM was performed by CalOptima's A&O Committeedepartment to determine performance related to the threshold of 98%. On a quarterly basis, each of the delegates were monitored for the following activities by reviewing a sample of prior authorization referral files:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Timeliness of decision and notification
- Clinical Decision Making
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness

The delegated HNs range of performance for timely decision making ranged from 89% - 99% compliance, with 8/10 HNs meeting the thresholded at 98% compliance rate for timeliness of decision and notification for routine pre-service authorizations. For expedited requests, the HNs performance ranged from 89-100%, with 9/10 HNs meeting the threshold, scoring 97%, had a negative variance to goal of 1%.

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are denied or modified. In 20182019, the HN files rangedperformance ranged between 85 10056-100%, with 3/9 HNs reaching the threshold for routine requests and 0-100%, with 5/8 reaching threshold for urgent requests. This is an opportunity for improvement and the Audit and Oversight Department requires a corrective action plan for these health networks not meeting the regulatory requirement for clinical decision making compliance with the standard representing an opportunity for continued focus in this area.

Notifications

The delegated HNs are audited regularly on member notifications (NOADs). In 20182019, compliance to standard ranged from 53 10062-99%, with 2/9 reaching the threshold for routine notifications and 55-100%, with 3/9 HNs reaching the threshold for urgent notifications. ;tThis continues to be a focus for improvement and corrective action plans have been issued by the Audit and Oversight Department to ensure that initiatives are put in place by the HSs to reach and maintain compliance.

OC

In 20182019, oversight of the delegated HNs for UM was performed by CalOptima's A&O Committeedepartment against the threshold of 98%. On a monthly basis, each of the delegates were monitored for the following activities by reviewing a sample of their prior authorization referral files:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff

20182019 CalOptima Utilization Management Program Evaluation

- Timeliness of decision and notification
- Clinical Decision Making
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness
The delegated HNs range of performance for clinical decision makingperformed at ranged from 8571–100%, with 6/7 HNs meeting the threshold for routine referral timeliness and 43-100%, with 3/7 HNs meeting the threshold for urgent referral timeliness of compliance rate for timeliness of decision and notification for routine pre-service authorizations. For expedited requests, the HNs, scoring 83–100%, had opportunities for improvement. This is an area of continued focus and due to the low membership, one case out of compliance could put the HN below the compliance threshold. Audit and Oversight issues corrective action plans to ensure the HNs are putting initiatives in place to reach and maintain compliance with timeliness.

Clinical Decision Making
The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are approved, denied or modified. The 20182019 HN performance scores ranged from 72% (53-100%, with 2/7 HNs meeting the threshold for routine referrals and 1 HN at 96% compliance for urgent. Again, due to the small membership in the OC product, one noncompliant case can render the HN below the threshold. Corrective action plans are issued by Audit and Oversight to ensure the HN meets and maintains compliance.one outlier) to 100%.

Notifications The delegated HNs are audited regularly on member notifications (NOADs). In 20182019, compliance to standard ranged fromperformance ranged from 81 95–100%, with 4/7 meeting the threshold for routine cases and 81-100%, with 3/8 HNs meeting threshold for urgent casesrepresenting significant improvement over 2017.
As with timeliness and clinical decision-making performance, Audit and Oversight issue corrective action plans to ensure initiatives are put in place by the HN to reach and maintain compliance.

20182019 CalOptima Utilization Management Program Evaluation

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal (MC) Shared Risk Average Length of Stay (ALOS): Trended downward in Q1-3 20182019 for Seniors and Persons with Disabilities (SPD)SPD). The trend for members in the Temporary Assistance for Needy Families (TANF) > 18 aid code categaorycategory has shown an increase in ALOS for this population as compared to 2018 performance. and remained stable and at 3.0 orThere was some fluctuation below for members in the aid category TANF < 18.

- **Bed Days/Per Thousand Member Months Per Year (PTMPY):** 20182019 goal was met for SPD, TANF ≤18 in Q1, but exceeded goal for the remaining quarters, attributed to the increased complexity of the population following WCM implementation in Q 3. TANF >18 attained goal for all quarters. SPD attained goal with the exception of Q1.178%.
- **Readmissions:** Stable Trend Q1-3; SPD average 23%, TANF > 18 average 17.35.6%, TANF ≤ < 18 average 2.93.16%
- **ED Visits/PTMPY:**
  - **SPD:** goal was met in Q21 and Q32, goal exceeded by 102% in Q13
  - **TANF < 18:** goal was exceeded in Q1 and Q2, but met goal in Q20183
  - **TANF > 18:** goal was not met in Q1 and Q3Q1-3 in 2019

Shared Risk – MC	Goal	Q1	Q2	Q3
SPD				
ALOS	-	5.34.9	4.84.4	4.83.9
Bed Days/PTMPY	1120	1,2151,112	1,013942	1,004949
Readmissions	-	24%22%	24%24%	22%23%
ED Visits/PTMPY	700	714694	651689	666776
TANF >18				
ALOS	-	4.54.4	4.34.3	4.43.8
Bed Days/PMPY	360	306294	285299	307314
Readmissions	-	17%17%	19%16%	16%14%
ED Visits/PTMPY	430	448441	469428	444479
TANF ≤18				
ALOS	-	2.92.9	3.32.8	3.23.0
Bed Days/PTMPY	40	3648	4134	5240
Readmissions	-	6%2%	4%4%	8%1%

| ED Visits/PTMPY | 310 | 379426 | 324313 | 300331 |

Medi-Cal CCN

- **Average Length of Stay**
  - **SPD:** Stable trend and remained relatively flat for Q1 – 3 2019.~~with slight spike to 5.3 in Q2~~
  - **TANF > 18:** Slow decline in ALOS noted quarter-over-quarter.~~Stable trend with average at 4.3 days~~
  - **TANF < 18:** Q2 trended down for Q2, however, Q3 more than doubled from Q2 which may reflect the implementation of WCM July 1, 2019.~~goal was not met in 2018 but trended down in Q1-3~~
- **Bed Days/PTMPY:** ~~2018~~2019 Bed Days goals were met for ~~each of the subpopulations~~both TANF populations; SPD bed days increased during Q2 and then slight decrease in Q3, but both quarters were above goal. There are many variables that could impact the increased bed days for these quarters, however, the decrease from Q2 to Q3 may be due to special cause variation that has not been determined at this time.
- **Readmissions:** ~~Stable Trend Q1-3; SPD average 24%, TANF > 18 average 21%, TANF < 18 average 2%~~SPD readmissions increased by 1 percentage point quarter-over-quarter. Readmission increase from Q 1– to Q2 for TANF > 18, but Q3 dropped below Q1 rate. TANF ≤18 increased Q1, which may be related to the flu season, dropped for Q2 and then shot up Q3 most likely due to the WCM implementation July 1, 2019.
- **ED Visits/PTMPY**
  - **SPD:** goal was not met in ~~2018~~2019
  - **TANF > 18:** goal was not met in ~~2018~~2019
  - **TANF < 18:** goal was not met in Q1 ~~2018~~2019; ~~not~~ met in Q2 and Q3

CCN	Goals	Q1	Q2	Q3
SPD				
ALOS	–~~-~~	5.1~~5.14.4~~	5.1~~5.15.3~~	5.0~~5.04.6~~
Bed Days/PTMPY	1830~~18301830~~	1,773~~1,7731,679~~	1,917~~1,9171,763~~	1,875~~1,8751,784~~
Readmissions	–~~-~~	31%~~31%25%~~	32%~~32%25%~~	33%~~33%23%~~
ED Visits/PTMPY	640~~640640~~	940~~940932~~	967~~967891~~	903~~9031,027~~
TANF >18				
ALOS	–~~-~~	5.3~~5.34.5~~	5.1~~5.14.3~~	5.0~~5.04.0~~
Bed Days/PMPY	710~~710710~~	577~~577465~~	529~~529472~~	515~~515458~~
Readmissions	–~~-~~	27%~~27%22%~~	30%~~30%22%~~	26%~~26%18%~~

ED Visits/PTMPY TANF≤18	490490**490**	630630 **622**	649649 **623**	612612**685**
ALOS	--	3.03.04 **.0**	2.22.22 **.2**	4.94.9**2.2**
Bed Days/PTMPY	100100**100**	515165	292928	797932
Readmissions	--	6%6%**6 %**	3%3%**0 %**	7%7%**0%**
ED Visits/PTMPY	470470**470**	497497 **545**	388388 **419**	381381**429**

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20182019 CalOptima Utilization Management Program Evaluation

The CalOptima Direct Administrative (CODA) 20182019 Bed Day and ED visit goals for the year were met for SPD;, TANF > 18 bed days were above goal for Q2 and 3 and below goal for ED visits except for the first quarter for TANF members ≤18 for Bed Days and ED visits were slightly above goal in Q1. TANF ≤ 18 bed days were above goal for Q 1 and Q3, but below goal for Q2. The spike in bed days for Q3 are attributable to the WCM implementation July 1, 2019. ED visits were below goal for all 3 Quarters. The low values are attributable to a smaller population for the CODA.

COD	Goals	Q1	Q2	Q3
SPD				
ALOS	--	5.75.75.3	5.95.95.4	5.75.74.9
Bed Days/PTMPY	192019201920	821821926	843843856	930930657
Readmissions	--	4%4%3%	4%4%3%	4%4%2%
ED Visits/PTMPY	112011201120	2274	5576	7775
TANF >18				
ALOS	--	5.65.64.7	6.16.15.1	6.16.14.2
Bed Days/PMPY	600600600	462462362	617617447	699699374
Readmissions	--	9%9%17%	13%13%16%	11%11%10%
ED Visits/PTMPY	580580580	1515384	1414429	4545449
TANF≤18				
ALOS	--	3.13.13.0	2.92.93.7	13.113.13.2
Bed Days/PTMPY	757575	101101 84	7575 49	625625 45
Readmissions	--	3%3%3%	4%4%0%	1%1%0%
ED Visits/PTMPY	400400400	2218	00314	00295

One-Care Connect Shared Risk results show progressive improvement in both Bed Days and ED Visits over the course of the year, apart from the third quarter for members in the TANF group. The low values for TANF > 18 bed days and readmissions are noted and warrant additional analyses to be reported at the UMC in 2020, with the appropriate interventions to improve performance as warranted.

This may be due to the virulent flu season in 2018.

Shared Risk - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	--	5.15.14.5	4.74.75.0	4.94.94.5
Bed Days/PTMPY	1340134 01340	1,2021 ,20285 2	1,0181,0 181,065	1,0161 ,01691 2
Readmissions	--	20%20 %19%	20%20% 20%	20%20 %17%
ED Visits/PTMPY	410410410	432432 385	414414422	39739 7432
TANF>18				
ALOS	--	6.56.53.8	0.00.04.9	7.57.54.5
Bed Days/PTMPY	--	1,1061 ,10659 4	001,012	1,0941 ,09487 3
Readmissions	--	0%0%5%	0%0%11 %	0%0%- 10%
ED Visits/PTMPY	--	471471 509	537537481	44844 8493

NOTE: No Established Goal for OCC Shared Risk TANF > 18

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20182019 CalOptima Utilization Management Program Evaluation

OCC CCN demonstrated improvement in bed day utilization in 20182019, though ED usage was higher than anticipated, especially during Q2 for the TNF > 18 population and this same population with a sharp decline in Q3. 2018 OCC CCN Data will be reviewed in 2019, and additional interventions may be applied as needed. These trends warrant additional analyses to be reported at the UMC in 2020, with the appropriate interventions to improve performance as warranted.

CCN - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	--	5.65.65.2	6.56.54.4	5.35.35.3
Bed Days/PTMPY	198019801980	1,4421,4421,573	1,7291,7291,138	1,6721,6721,064
Readmissions	--	22%22%14%	33%33%22%	26%26%11%
ED Visits/PTMPY	410410410	627627609	587587600	635635680
TANF>18				
ALOS	--	5.15.13.8	4.14.16.1	1.01.03.7
Bed Days/PTMPY	--	1,1971,1971,437	1,6681,6681,919	8686975
Readmissions	--	0%0%24%	0%0%18%	0%0%19%
ED Visits/PTMPY	--	350350594	1,6611,661697	5945941,082

OC results were variable, likely related to the small population size, but did show improvement in bed day utilization for the first three quarters

OC	Goals	Q1	Q2	Q3
ALOS	--	5.15.16.3	5.25.25.1	4.04.04.1
Bed Days/PTMPY	1370137011370	1,1001,1001,238	787787857	508508642
Readmissions	--	10%10%20%	19%19%12%	11%11%4%
ED Visits/PTMPY	480480480	509509420	393393419	431431439

20182019 CalOptima Utilization Management Program~~ ~~Evaluation

Over and Underutilization is monitored, tracked, managed and reported by ~~Quality Analytics, Quality Improvement,~~ UM ~~and Case Management~~during 2019 and reported to ~~QIC, UMC, and QAC by product at least~~ ~~quarterly in 2018~~UMC, QIC and the Quality Assurance Committee (QAC). ~~Data analysis reveals 2018 ED utilization that exceeds goals and will continue to be~~ ~~evaluated and considered as care is planned and coordinated for CalOptima members.~~

The data do not reveal any significant variation in data warranting immediate intervention, however, a robust organization-wide over and underutilization monitoring process will be developed and reported to the appropriate committees during 2020.

III   Operational Performance

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

A.   **(This includes inpatient, outpatient and physician services).**

20182019 - Summary of referral volume (Quarter 1Quarter 3)

Referrals Processed		Referrals Received		Turnaround Time Compliancy (TAT)	
Routine:~~Routine:~~	**123,729**~~150,494~~	Faxed:		Routine	**99.95%**
Urgent:~~Urgent:~~	**15,283**~~16,803~~	~~Faxed:~~Faxe	**90,124**78,074	TAT:~~Routine TAT:~~Urgent	**99.95%**99.9%
Retro:~~Retro:~~	**7,539**7,645	~~COLAS:~~COLAS	**100,542**96,414	TAT:~~Urgent TAT:~~Retro TAT:Retro	**99.45%**99.1%
Total:~~Total:~~	**146,551***~~174,942*~~	∴ Total:	**190,666**174,488	TAT:	**99.76%**99.5%

Total volume of referrals increased from 2018 by 28,391 or 16.2% ~~2017 by 48,335 or 38.2%~~ Volume of faxed referrals increased from 2018 by 12,050 or 13.3%~~2017 by 28,947 or 58.9%~~

Volume of portal (COLA) referrals increased from 2018 by 3,302 or 3.2% ~~2017 by 17,590 or 22.1%~~

*The difference between referrals received and processed may be attributed to duplicate submissions and/or requests that do not require authorization.

Online Referral Rate Submission
Online referral submission ~~rate over~~increased over the 3 quarters ~~was 55%~~by 11 ~~in~~% in 20182019. In 2018, Q1-Q3, there were 91,334 online referrals and during the same period of 2019, there were 100,542.
~~and was 63% over 4 quarters of~~ ~~2017.~~

Referral TAT was compliant for all referral types in the first 3 quarters of 20182019.

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

20182019 CalOptima Utilization Management Program Evaluation

Annual summary of turnaround time compliance, through
3Q19:2018:
OC: 100100%
OCC: 99.77%
Medi-Cal: 98.8%

Pharmacy Prior Authorization TAT processing time are above the goal of 987% for ~~OC and OCC~~all plans. ~~The TAT for Medi-Cal fell below goal in 2Q17 due to a change in the PBM PA system.~~ Pharmacy metric targets   were achieved for 20182019.

C. Authorization for Expedited / Urgent / Routine / Retro Requests – LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric targets were achieved for 20182019 (Q1-3):
    o CBAS CEDT: 100%
    o CBAS Routine: 99100%
    o CBAS Expedited: None received
        - Members participating in CBAS Q1-Q3 2019: Potentially program-eligible members

        QTR 1:
        OCC: 180/14,186 (1.27%) = Increase
        Medi-Cal: 2,457/111,227 (2.21%) = No Change

        QTR 2:
        OCC: 193/14,213 (1.36%) = Increase
        Medi-Cal: 2,500/114,939 (2.18%) = Decrease

        QTR 3:
        OCC: 205/14,171 (1.45%) = increase
        Medi-Cal: 2,568/101,012 (2.54%) = increase
        - 80% of authorized CBAS participation days will be utilized/delivered (Q1-Q3 2019).

        QTR 1:
        101,754 Days Used of 128,785 Authorized (79.01%)

        QTR 2:
        107,281 Days Used of 133,148 Authorized (80.57%)

        QTR 3:
        107,281 Days Used of 133,148 Authorized (80.57%)
        o Goal Met: Continue to monitor
    o LTC Routine: 10098.99%
    o LTC Urgent: None received
    o MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

        QTR 1:
        OCC: 180/14,186 (1.27%) = Increase
        Medi-Cal: 2,457/111,227 (2.21%) = No Change

        QTR 2:
        OCC: 193/14,213 (1.36%) = Increase
        Medi-Cal: 2,500/114,939 (2.18%) = Decrease

QTR 3:
OCC: 205/14,171 (1.45%) = increase
Medi-Cal: 2,568/101,012 (2.54%) = increase

MSSP Goal met. Continue with this goal.

D. **Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.**

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for 20182019. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

> UM Clinical Staff:
> > Prior Authorization: 90%
> > Concurrent Review: 90%
> Physicians: 97%
> Pharmacy: 100%
> LTSS: LTC tested on Q3 for an average of 95.7%, CBAS tested in Q3 for an average of 96.6% and MSSP did not test in 201995%

E. **Denial (Letter) Process**

Performance has continued to improve throughout 20182019. A specific area of focus was the appropriate   lay language, which has demonstrated significant improvement, though there remains some   variability across the HNs. A workgroup begun in 20182019 consisting of participants from CalOptima UM,   BHI, Pharmacy, GARS and A&O that will continue to identify and share best practices to attain further   improvement in this area. NCQA 20182019 Survey demonstrated full compliance with the denial process   across CCN and the HNs selected for review.

III.   Utilization Performance / Outcomes

A.   **Facility Utilization – Facility Acute and Emergency Care**

Analysis of inpatient and ED data in 20182019 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.established goals for this metric, as evidenced on the preceding Inpatient and Emergency Department Utilization Performance tables.

Review of 20182019 ED Data will be conducted, and additional interventions may be applied as needed.

LTSS Program Members admitted to LTC NF Q1-Q3 2019: A total of 21 CBAS were admitted to an LTC for the first 3 quarters of 2019.

CBAS: Track CBAS participants who transition to LTC. Goal: To be determined after establishing baseline.

> QTR 1:
> Medi-Cal: 5/2,457 (0.20%)
> OCC: 1/180 (0.55%)
>
> QTR 2:
> Medi-Cal: 8/2,500 (0.32%)
> OCC: 0/193 (0.0%)
>
> QTR 3:
> Medi-Cal: 6/2,568 (0.23%)
> OCC: 1/205 (0.49%)

LTC: Members residing in LTC:

> QTR 1:
> OCC: 220/14,186 (1.55%) = decrease
> SPD: 5,098/111,227 (4.58%) = Increase
>
> QTR 2:
> OCC: 200/14,213 (1.41%) = decrease
> SPD: 5,101/114,939 (4.44%) = Decrease
>
> QTR 3:
> OCC: 196/14,171 (1.38%) = decrease
> Medi-Cal: 5,130/101,012 (5.26%) = increase

B.   Pharmacy Utilization

Outpatient pharmacy utilization increases in 2019 are primarily driven by increased utilization of diabetes medications and seasonal increases in analgesics and antibiotics during the cold and flu season.

Opioid analgesic utilization (average morphine milligram equivalent) has decreased 17.6% from 3Q18 to 3Q19.

- Retail Pharmacy: $PMPM costs for all LOB are below goal
- Diabetes drug utilization is the second highest drug class by cost for OCC and highest for Medi Cal. Opioid analgesic utilization has decreased 8.5% from 3Q17 to 3Q18. Medi Cal: Goal $ PMPM $54.13, actual CY18 through 3Q18 $52.60 OC: Goal $ PMPM $354.63, actual CY18 through 3Q18 $337.30 OCC: Goal $ PMPM $380.33, actual CY18 through 3Q18 $373.40

C.   Member and Provider Satisfaction

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:
- Providing information to members and providers about the UM Program
  - Members are informed about authorization requirements through the Member Handbook and member newsletters
  - New member orientation is available for all CalOptima members to better understand their benefits
  - Access to a list of services requiring pre-authorization is also available on CalOptima's website
  - CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed
  - Providers receive on-site visits from CalOptima's Provider Relations team, who provide tools and references for requesting authorizations for their members
  - A Provider Toolkit is available on the CalOptima website for provider reference
  - CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers
- Ensuring timeliness and notification of UM decisions
  - Monitored and reported quarterly to UMC: In 20182019, the percent of authorization requests completed in a timely manner overall exceeded 97.5%
- Consistent use of approved, evidence-based guidelines in clinical decision making
  - Monitored monthly by the A&O Committee
  - Variation among the delegated HNs
  - Additional training provided as needed
  - Overall improvement in audit scores for clinical decision making in 20182019

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In 20182019, complaints about the UM Program demonstrated some trends in the following categories:

- Member Education
    - o Pharmacy Home Program and quantity limits on opioid medications
    - o Quality of service by pain management practitioners
    - o Supplemental dental benefits

> o There was a significant decrease in the number of complaints about transportation by OC and OCC members. This is clearly due to the new Medi-Cal non-medical transportation benefit, which became effective in July 20182019

- Provider concerns:
  - o Redirection from tertiary level of care for non-complex condition management
  - o Level of payment disputes, especially from non-participating and/or out of area providers

While member concerns regarding the Pharmacy Home Program and quantity limits on opioid medications have risen, these controls remain as efforts to impact the strengthening opioid crisis. Provider, member and community education on the cautious and appropriate use of these medications will promote understanding of these programs. Complaints about pain management practitioners is likely a related issue. However, oversight of these providers and prompt review of any quality concerns will continue; appropriate peer review activities are performed by the Credentialing and Peer Review Committee.

CalOptima has worked closely with Liberty Dental to address complaints regarding supplemental dental benefits and recent updates to the contract should improve member experience. OCC and OC members will not have the option to select Liberty dental in 2019. The only dental benefits they have is Denti-Cal, which they will be referred to.

Provider disputes regarding redirection from tertiary level of care have begun to trend downward as CalOptima has strengthened the regular communication with UCI Medical Center through quarterly joint operations meetings. Education continues with out of area and out of network providers regarding appropriate billing practices, especially for Medi-Medi members.

IV   Summary

In 20182019, CalOptima made progress improving the effectiveness of the UM program and decreasing   administrative barriers. We also brought on a pool of expertise to enhance our programs, including a pediatric physician with CCS expertise to assist with WCM. Major initiatives included improvements to CalOptima's medical   management system and network data interfaces as well as continued focus on Compliance,   maintenance of current policies and procedures, report development, preparation for the Whole-Child Model transition leveraging existing processes and model(s) of care.

The UMC and the UM Medical Director continue to guide and support CalOptima UM programs, as well as the Deputy CMO position which was resurrected and filled during 2019. New management staff were brought on during Q3 of 2019, which includes a UM Director and PA Manager. Our overall referral volume increased during 2019, however, compliance with regulatory standards remained strong for CCN/COD. Deficiencies in HN performance as noted in the preceding "UM Delegated Provider Oversight" section were identified by the Audit and Oversight team and CAPs were issued.

2019 CalOptima Utilization Management Program Evaluation

Executive Summary

The 2019 Utilization Management (UM) Program describes CalOptima's activities to promote optimum utilization of health care services for our members delivered in a high-quality, compassionate and cost-effective manner.

This evaluation of UM activity is completed annually and approved by the Utilization Management Committee (UMC), the Quality Improvement Committee (QIC), the Quality Assurance Committee (QAC) and CalOptima's Board of Directors.

There have been no changes to the overall UM program structure elements listed below during 2019. The program structure elements are:

- UM staff assigned activities;

- UM staff who have the authority to deny coverage;

- Involvement of a designated physician and a designated behavioral healthcare practitioner;

- The process for evaluating, approving and revising the UM program, and those responsible for each step;

- The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities; and

- The process for handling appeals and making appeal determinations.

Projects, Programs and Initiatives:

A. Utilization Management
In 2019, the UM department initiated several projects to support improved efficiency, decreased administrative burden and improved quality of provider and member facing documentation. These projects included:
- Upgrades/enhancements to the Guiding Care (GC) Utilization Review Module in CalOptima's medical management system
- Desktop Procedures – cataloged, reviewed and updated
- Continued development of CalOptima Reporting Environment (CORE) to align operational reports with the data structure in GC and to continue to identify opportunities for process improvement
- Successful transition on July 1, 2019 of CalOptima members eligible with the California Children's Services Program (CCS) to the Whole Child Model (WCM) Program.

- Ensured all policies and procedures were in effect in accordance with regulatory requirements and accurately represent clinical operations processes.

The Medical Director of UM provides clinical oversight for the administration of the UM Program and has been very engaged during 2019. He/she supports the UM process by ensuring that treatment requests are processed in accordance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluating the program's effectiveness against established goals. For UM Program areas that do not meet the approved goals, modifications to program activities are proposed by leadership to the UM Workgroup (UMWG). As endorsed by the UMWG, the updated plan is presented and approved by the Utilization Management Committee (UMC). These changes are implemented by the UM Leadership and department staff. The UM Medical Director supports provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). This subcommittee evaluates new and modified benefits to determine the need for prior authorization. He/she also chairs the bi-weekly UMWG, which provides input to the development and processes of UM Program to ensure quality, cost efficient services and care are delivered to CalOptima members. The UM Medical Director led discussions with the nursing and physician group in semiweekly concurrent review case rounds, discussing appropriate care guidelines, clinical and practical aspects of managing medically complex members in the acute and post-acute care settings and assisting with discharge planning management. He also provided education to the team to ensure understanding of the clinical basis for decisions..

The UM Medical Director also provided focused education on specific topics including: genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, the Letter of Agreement (LOA) process, and evaluation of the appropriateness of one-day inpatient stays.

In 2019, the UM Medical Director adequately supported the UM process and met the needs of the UM team through education, case review and availability.

B. Behavioral Health Integration

In 2019, CalOptima continued to manage all the administrative functions of Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima members, including UM, claims, provider network, credentialing, member services, care coordination, and Quality Improvement (QI. The Behavioral Health Integration (BHI) department worked closely with other departments to ensure the provision of treatment was in accordance with mental health parity legislation and the prior authorization process complied with all federal, state, contractual, regulatory and accreditation guidelines.

For OneCare (OC) and OneCare Connect (OCC), Magellan Health served as CalOptima's Managed Behavioral Health Organization (MBHO) with the full spectrum of administrative responsibilities including UM, provider network, credentialing, customer service, inpatient services, and care coordination. BHI maintained a close working relationship with Health Network (HN) management providing oversight of the MBHO's delivery of the mental health services and administrative functions.

The Behavioral Health Quality Improvement (BHQI) Subcommittee was held on a quarterly basis and reported to the Quality Improvement Committee (QIC). The BHQI trends, analyzes and identifies improvement areas for behavioral health (BH) services, ensures access to quality BH care, and enhances continuity and coordination between behavioral health and physical health care providers The BHQI is chaired by the BH Medical Director and is comprised of internal and external members, which include delegated health network participants, community partners, behavioral health practitioners, and the Orange County Mental Health Plan (MHP), administered by the Orange County Health Care Agency (OC HCA). The chair is responsible for leading and presenting subcommittee recommendations to the QIC. In addition, a BHQI workgroup met regularly throughout 2019 for additional work and analysis on BH quality initiatives. This group served to address suggestions from the BHQI that assisted with strengthening interventions, data review and key areas for improving the member experience. In 2019, the BH Medical Director provided critical support for establishing key BH processes of monitoring utilization. Utilization triggers were developed to identify potential over utilization and to determine if the mild to moderate benefit was an appropriate level of care for the member.

C. UM Data Management

UM report design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Services (IS) department staff. Together with UM department subject matter experts, EA and IS maintained a focused effort to improve the understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima and the delegated health networks. Further refinement of data (XML) file format f o r health network submission of data elements including authorization information led to increased reliability of reports and improved the usefulness of information.. Additional efforts are planned to leverage availability of this information to UM, Quality and Audit and Oversight (A&O) by configuring standard queries of the data mart.

D. UM Delegated Provider Oversight

Medi-Cal
In 2019, oversight of the delegated HNs for UM was performed by CalOptima's Audit and Oversight (A&O) department. Monthly, each HN was monitored by reviewing a sample of prior authorization referral files against the threshold of 98% for the following activities:
- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness:
The delegated HNs performance for timely decision making ranged from 88-99% for routine pre-service referrals and 86-99% for urgent pre-service referrals. The established threshold for timeliness of clinical decision and notification is 98%. 90% of the health networks met threshold for routine pre-service referrals (10 of 11) and 81% (9 of 11) met the threshold for urgent pre-service referrals.

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CalOptima's A&O department issued corrective action plans (CAP) to the HNs for all performance less than the established threshold.

Clinical Decision Making
The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are approved, denied or modified. In 2019, the HN files ranged between 56–100% compliance with the standard for urgent files reviewed. For routine files reviewed, compliance ranged from 64-100%. Audit and Oversight reviews files on a regular basis and initiates CAPs for performance less than the established threshold.

Notifications
The delegated HNs are audited regularly for compliance with regulatory standards related to member notification of denials (NOAs). In 2019, compliance with the standard ranged from 64 -100% for urgent and 66-100% for routine HN referrals reviewed. Audit and Oversight reviews files on a regular basis and initiates CAPs for performance less than the established threshold.

OCC
In 2019, oversight of the delegated HNs for UM was performed by CalOptima's A&O department to determine performance related to the threshold of 98%. On a   quarterly basis, each of the delegates were monitored for the following activities by reviewing a sample of prior authorization referral files:
- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness
The delegated HNs range of performance for timely decision making ranged from 89% - 99% compliance, with 8/10 HNs meeting the threshold for timeliness of decision and notification for routine pre-service authorizations. For expedited requests, the HNs performance ranged from 89-100%, with 9/10 HNs meeting the threshold

Clinical Decision Making
The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are denied or modified. In 2019, the HN performance ranged between 56-100%, with 3/9 HNs reaching the threshold for routine requests and 0-100%, with 5/8 reaching threshold for urgent requests. This is an opportunity for improvement and the Audit and Oversight Department requires a corrective action plan for these health networks not meeting the regulatory requirement for clinical decision making.

Notifications
The delegated HNs are audited regularly on member notifications (NOAs). In 2019, compliance to standard ranged from 62-99%, with 2/9 reaching the threshold for routine notifications and 55-100%, with 3/9 HNs reaching the threshold for urgent notifications. This continues to be a focus for improvement and corrective action plans have been issued by the Audit and Oversight Department to ensure that initiatives are put in place by the HSs to reach and maintain compliance.

OC

In 2019, oversight of the delegated HNs for UM was performed by CalOptima's A&O department against the threshold of 98%. On a monthly basis, each of the delegates were monitored for the following activities by reviewing a sample of their prior authorization referral files:

- Timeliness of decision and notification to the provider
- Clinical Decision Making, including application of medical necessity criteria and decision made by correct level of staff
- Appropriate notification to provider and member (including guidelines cited and lay language at 6th grade level, preferred written language)

Timeliness

The delegated HNs range of performance for clinical decision making ranged from 71–100%, with 6/7 HNs meeting the threshold for routine referral timeliness and 43-100%, with 3/7 HNs meeting the threshold for urgent referral timeliness of decision and notification. This is an area of continued focus and due to the low membership, one case out of compliance could put the HN below the compliance threshold. Audit and Oversight issues corrective action plans to ensure the HNs are putting initiatives in place to reach and maintain compliance with timeliness.

Clinical Decision Making

The delegated HNs undergo regular auditing of UM files to validate the appropriateness of clinical decision making for requests that are approved, denied or modified. The 2019 HN performance ranged from 53-100%, with 2/7 HNs meeting the threshold for routine referrals and 1 HN at 96% compliance for urgent. Again, due to the small membership in the OC product, one noncompliant case can render the HN below the threshold. Corrective action plans are issued by Audit and Oversight to ensure the HN meets and maintains compliance.

Notifications The delegated HNs are audited regularly on member notifications (NOAs). In 2019, performance ranged from 81-100%, with 4/7 meeting the threshold for routine cases and 81-100%, with 3/8 HNs meeting threshold for urgent cases.

As with timeliness and clinical decision-making performance, Audit and Oversight issue corrective action plans to ensure initiatives are put in place by the HN to reach and maintain compliance.

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal (MC) Shared Risk

- **Average Length of Stay (ALOS):** Trended downward in Q1-3 2019 for Seniors and Persons with Disabilities (SPD). The trend for members in the Temporary Assistance for Needy Families (TANF) > 18 aid code category has shown an increase in ALOS as compared to 2018 performance. There was some fluctuation for members in the aid category TANF < 18.
- **Bed Days/Per Thousand Member Months Per Year (PTMPY):** 2019 goal was met for TANF ≤18 in Q1, but exceeded goal for the remaining quarters, attributed to the increased complexity of the population following WCM implementation in Q 3. TANF >18 attained goal for all quarters. SPD attained goal with the exception of Q1.
- **Readmissions:** Stable Trend Q1-3; SPD average 23%, TANF > 18 average 17.3%, TANF ≤ 18 average 6%
- **ED Visits/PTMPY:**
  - **SPD:** goal was met in Q2 and Q3, goal exceeded by 2% in Q1
  - **TANF < 18:** goal was exceeded in Q1 and Q2, but met goal in Q3
  - **TANF > 18:** goal was not met Q1-3 in 2019

Shared Risk – MC	Goal	Q1	Q2	Q3
SPD				
ALOS	-	5.3	4.8	4.8
Bed Days/PTMPY	1120	1,215	1,013	1,004
Readmissions	-	24%	24%	22%
ED Visits/PTMPY	700	714	651	666
TANF >18				
ALOS	-	4.5	4.3	4.4
Bed Days/PMPY	360	306	285	307
Readmissions	-	17%	19%	16%
ED Visits/PTMPY	430	448	469	444
TANF ≤18				
ALOS	-	2.9	3.3	3.2
Bed Days/PTMPY	40	36	41	52
Readmissions	-	6%	4%	8%

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ED Visits/PTMPY	310	379	324	300

Medi-Cal CCN

- **Average Length of Stay**
    - **SPD:** Stable trend and remained relatively flat for Q1 – 3 2019.
    - **TANF > 18:** Slow decline in ALOS noted quarter-over-quarter.
    - **TANF ≤ 18:** Q2 trended down for Q2, however, Q3 more than doubled from Q2 which may reflect the implementation of WCM July 1, 2019.
- **Bed Days/PTMPY:** 2019 Bed Days goals were met for both TANF populations; SPD bed days increased during Q2 and then slight decrease in Q3, but both quarters were above goal. There are many variables that could impact the increased bed days for these quarters, however, the decrease from Q2 to Q3 may be due to special cause variation that has not been determined at this time.
- **Readmissions:** SPD readmissions increased by 1 percentage point quarter-over-quarter. Readmission increase from Q 1– to Q2 for TANF > 18, but Q3 dropped below Q1 rate. TANF ≤18 increased Q1, which may be related to the flu season, dropped for Q2 and then shot up Q3 most likely due to the WCM implementation July 1, 2019.
- **ED Visits/PTMPY**
    - **SPD:** goal was not met in 2019
    - **TANF > 18:** goal was not met in 2019
    - **TANF ≤ 18:** goal was not met in Q1 2019; met in Q2 and Q3

CCN	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.1	5.1	5.0
Bed Days/PTMPY	1830	1,773	1,917	1,875
Readmissions	-	31%	32%	33%
ED Visits/PTMPY	640	940	967	903
TANF >18				
ALOS	-	5.3	5.1	5.0
Bed Days/PMPY	710	577	529	515
Readmissions	-	27%	30%	26%
ED Visits/PTMPY	490	630	649	612
TANF≤18				

ALOS	-	3.0	2.2	4.9
Bed Days/PTMPY	100	51	29	79
Readmissions	-	6%	3%	7%
ED Visits/PTMPY	470	497	388	381

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CalOptima Direct Administrative (CODA) 2019 Bed Day and ED visit goals for the year were met for SPD; TANF > 18 bed days were above goal for Q2 and 3 and below goal for ED visits. TANF ≤ 18 bed days were above goal for Q 1 and Q3, but below goal for Q2. The spike in bed days for Q3 are attributable to the WCM implementation July 1, 2019. ED visits were below goal for all 3 Quarters. The low values are attributable to a smaller population for the CODA.

COD	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.7	5.9	5.7
Bed Days/PTMPY	1920	821	843	930
Readmissions	-	4%	4%	4%
ED Visits/PTMPY	1120	2	5	7
TANF >18				
ALOS	-	5.6	6.1	6.1
Bed Days/PMPY	600	462	617	699
Readmissions	-	9%	13%	11%
ED Visits/PTMPY	580	15	14	45
TANF≤18				
ALOS	-	3.1	2.9	13.1
Bed Days/PTMPY	75	101	75	625
Readmissions	-	3%	4%	1%
ED Visits/PTMPY	400	2	0	0

OneCare Connect Shared Risk results show progressive improvement in both Bed Days and ED Visits over the course of the year, apart from the third quarter for members in the TANF group. The low values for TANF > 18 bed days and readmissions are noted and warrant additional analyses to be reported at the UMC in 2020, with the appropriate interventions to improve performance as warranted.

Shared Risk - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.1	4.7	4.9
Bed Days/PTMPY	1340	1,202	1,018	1,016
Readmissions	-	20%	20%	20%
ED Visits/PTMPY	410	432	414	397
TANF>18				
ALOS	-	6.5	0.0	7.5
Bed Days/PTMPY	-	1,106	0	1,094
Readmissions	-	0%	0%	0%
ED Visits/PTMPY	-	471	537	448

NOTE: No Established Goal for OCC Shared Risk TANF > 18

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OCC CCN demonstrated improvement in bed day utilization in 2019, though ED usage was higher than anticipated, especially during Q2 for the TNF > 18 population and this same population with a sharp decline in Q3. These trends warrant additional analyses to be reported at the UMC in 2020, with the appropriate interventions to improve performance as warranted.

CCN - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.6	6.5	5.3
Bed Days/PTMPY	1980	1,442	1,729	1,672
Readmissions	-	22%	33%	26%
ED Visits/PTMPY	410	627	587	635
TANF>18				
ALOS	-	5.1	4.1	1.0
Bed Days/PTMPY	-	1,197	1,668	86
Readmissions	-	0%	0%	0%
ED Visits/PTMPY	-	350	1,661	594

OC results were variable, likely related to the small population size, but did show improvement in bed day utilization for the first three quarters

OC	Goals	Q1	Q2	Q3
ALOS	-	5.1	5.2	4.0
Bed Days/PTMPY	1370	1,100	787	508
Readmissions	-	10%	19%	11%
ED Visits/PTMPY	480	509	393	431

Over and Underutilization is monitored, tracked, managed and reported by UM during 2019 and reported to UMC, QIC and the Quality Assurance Committee (QAC). The data do not reveal any significant variation in data warranting immediate intervention, however, a robust organization-wide over and underutilization monitoring process will be developed and reported to the appropriate committees during 2020.

III   Operational Performance

A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests – Medical (This includes inpatient, outpatient and physician services).

2019 - Summary of referral volume (Quarter 1Quarter 3)

Referrals Processed		Referrals Received		Turnaround Time Compliancy (TAT)	
Routine:	**123,729**	Faxed:	**90,124**	Routine TAT:	**99.95%**
Urgent:	**15,283**	Colas:	**100,542**	Urgent TAT:	**99.45%**
Retro:	**7,539**	COLAS:		Retro TAT:	**99.76%**
Total:	**146,551***	**Total:**	**190,666**		

Total volume of referrals increased from 2018 by 28,391 or 16.2%

Volume of faxed referrals increased from 2018 by 12,050 or 13.3%

Volume of portal (COLA) referrals increased from 2018 by 3,302 or 3.2%

*The difference between referrals received and processed may be attributed to duplicate submissions and/or requests that do not require authorization.

Online Referral Rate Submission

Online referral submission increased over the 3 quarters by 11% in 2019. In 2018, Q1-Q3, there were 91,334 online referrals and during the same period of 2019, there were 100,542.

Referral TAT was compliant for all referral types in the first 3 quarters of 2019.

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

Annual summary of turnaround time compliance, through
> 3Q19::
> OC: 100%
> OCC: 99.7%
> Medi-Cal: 98.8%

Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans. Pharmacy metric targets   were achieved for 2019.

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C. Authorization for Expedited / Urgent / Routine / Retro Requests – LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric targets were achieved for 2019 (Q1-3):
    - CBAS CEDT: 100%
    - CBAS Routine: 100%
    - CBAS Expedited: None received
        - Members participating in CBAS Q1-Q3 2019: Potentially program-eligible members
          QTR 1:
          OCC: 180/14,186 (1.27%) = Increase
          Medi-Cal: 2,457/111,227 (2.21%) = No Change

          QTR 2:
          OCC: 193/14,213 (1.36%) = Increase
          Medi-Cal: 2,500/114,939 (2.18%) = Decrease

          QTR 3:
          OCC: 205/14,171 (1.45%) = increase
          Medi-Cal: 2,568/101,012 (2.54%) = increase
        - 80% of authorized CBAS participation days will be utilized/delivered (Q1-Q3 2019).
          QTR 1:
          101,754 Days Used of 128,785 Authorized (79.01%)

          QTR 2:
          107,281 Days Used of 133,148 Authorized (80.57%)

          QTR 3:
          107,281 Days Used of 133,148 Authorized (80.57%)
          Goal Met: Continue to monitor
    - LTC Routine: 98.99%
    - LTC Urgent: None received
    - MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.
        QTR 1:
        OCC: 180/14,186 (1.27%) = Increase
        Medi-Cal: 2,457/111,227 (2.21%) = No Change

        QTR 2:
        OCC: 193/14,213 (1.36%) = Increase
        Medi-Cal: 2,500/114,939 (2.18%) = Decrease

QTR 3:
OCC: 205/14,171 (1.45%) = increase
Medi-Cal: 2,568/101,012 (2.54%) = increase

MSSP Goal met. Continue with this goal.

D. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for 2019. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

> UM Clinical Staff:
> > Prior Authorization: 90%
> > Concurrent Review: 90%
> Physicians: 97%
> Pharmacy: 100%
> LTSS: LTC tested on Q3 for an average of 95.7%, CBAS tested in Q3 for an average of 96.6% and MSSP did not test in 2019

E. Denial (Letter) Process

Performance has continued to improve throughout 2019. A specific area of focus was the appropriate lay language, which has demonstrated significant improvement, though there remains some variability across the HNs. A workgroup begun in 2019 consisting of participants from CalOptima UM, BHI, Pharmacy, GARS and A&O that will continue to identify and share best practices to attain further improvement in this area. NCQA 2019 Survey demonstrated full compliance with the denial process across CCN and the HNs selected for review.

III.   Utilization Performance / Outcomes

A.   Facility Utilization – Facility Acute and Emergency Care

Analysis of inpatient and ED data in 2019 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than established goals for this metric, as evidenced on the preceding Inpatient and Emergency Department Utilization Performance tables.

Review of 2019 ED Data will be conducted, and additional interventions may be applied as needed.

LTSS Program Members admitted to LTC NF Q1-Q3 2019: A total of 21 CBAS were admitted to an LTC for the first 3 quarters of 2019.

CBAS: Track CBAS participants who transition to LTC. Goal: To be determined after establishing baseline.

QTR 1:
Medi-Cal: 5/2,457 (0.20%)
OCC: 1/180 (0.55%)

QTR 2:
Medi-Cal: 8/2,500 (0.32%)
OCC: 0/193 (0.0%)

QTR 3:
Medi-Cal: 6/2,568 (0.23%)
OCC: 1/205 (0.49%)

LTC: Members residing in LTC:

QTR 1:
OCC: 220/14,186 (1.55%) = decrease
SPD: 5,098/111,227 (4.58%) = Increase

QTR 2:
OCC: 200/14,213 (1.41%) = decrease
SPD: 5,101/114,939 (4.44%) = Decrease

QTR 3:
OCC: 196/14,171 (1.38%) = decrease
Medi-Cal: 5,130/101,012 (5.26%) = increase

B.   Pharmacy Utilization

Outpatient pharmacy utilization increases in 2019 are primarily driven by increased utilization of diabetes medications and seasonal increases in analgesics and antibiotics during the cold and flu season.

Opioid analgesic utilization (average morphine milligram equivalent) has decreased 17.6% from 3Q18 to 3Q19.

C.   Member and Provider Satisfaction

Member and Provider Satisfaction with the UM Program is important to CalOptima. The following approaches are incorporated into the UM Program to promote continuous improvement in this area:
- Providing information to members and providers about the UM Program
    o Members are informed about authorization requirements through the Member Handbook and member newsletters
    o New member orientation is available for all CalOptima members to better understand their benefits
    o Access to a list of services requiring pre-authorization is also available on CalOptima's website
    o CalOptima Customer Service and clinical staff are available to assist member's in accessing services, as needed
    o Providers receive on-site visits from CalOptima's Provider Relations team, who provide tools and references for requesting authorizations for their members
    o A Provider Toolkit is available on the CalOptima website for provider reference
    o CalOptima Link provides an easily accessed electronic means of requesting authorizations for providers
- Ensuring timeliness and notification of UM decisions
    o Monitored and reported quarterly to UMC: In 2019, the percent of authorization requests completed in a timely manner overall exceeded 97.5%
- Consistent use of approved, evidence-based guidelines in clinical decision making
    o Monitored monthly by the A&O Committee
    o Variation among the delegated HNs
    o Additional training provided as needed
    o Overall improvement in audit scores for clinical decision making in 2019

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In 2019, complaints about the UM Program demonstrated some trends in the following categories:
- Member concerns:
    o Pharmacy Home Program and quantity limits on opioid medications
    o Quality of service by pain management practitioners
    o Supplemental dental benefits
    o There was a significant decrease in the number of complaints about transportation by

OC and OCC members. This is clearly due to the new Medi-Cal non-medical transportation benefit, which became effective in July 2019

- Provider concerns:
  - Redirection from tertiary level of care for non-complex condition management
  - Level of payment disputes, especially from non-participating and/or out of area providers

While member concerns regarding the Pharmacy Home Program and quantity limits on opioid medications have risen, these controls remain as efforts to impact the strengthening opioid crisis. Provider, member and community education on the cautious and appropriate use of these medications will promote understanding of these programs. Complaints about pain management practitioners is likely a related issue. However, oversight of these providers and prompt review of any quality concerns will continue; appropriate peer review activities are performed by the Credentialing and Peer Review Committee.

CalOptima has worked closely with Liberty Dental to address complaints regarding supplemental dental benefits and recent updates to the contract should improve member experience. OCC and OC members will not have the option to select Liberty dental in 2019. The only dental benefits they have is Denti-Cal, which they will be referred to.

Provider disputes regarding redirection from tertiary level of care have begun to trend downward as CalOptima has strengthened the regular communication with UCI Medical Center through quarterly joint operations meetings. Education continues with out of area and out of network providers regarding appropriate billing practices, especially for Medi-Medi members.

IV   Summary

In 2019, CalOptima made progress improving the effectiveness of the UM program and decreasing administrative barriers. We also brought on a pool of expertise to enhance our programs, including a pediatric physician with CCS expertise to assist with WCM. Major initiatives included improvements to CalOptima's medical management system and network data interfaces as well as continued focus on Compliance,   maintenance of current policies and procedures, report development, preparation for the Whole-Child Model transition leveraging existing processes and model(s) of care.

The UMC and the UM Medical Director continue to guide and support CalOptima UM programs, as well as the Deputy CMO position which was resurrected and filled during 2019. New management staff were brought on during Q3 of 2019, which includes a UM Director and PA Manager. Our overall referral volume increased during 2019, however, compliance with regulatory standards remained strong for CCN/COD. Deficiencies in HN performance as noted in the preceding "UM Delegated Provider Oversight" section were identified by the Audit and Oversight team and CAPs were issued.

20 2020 2019

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

202019 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____   _____
Francesco FedericoHimmet Dajee, M.D.   **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____   _____
Paul Yost, M.D.   **Date**

Board of Directors Chair:

_____   _____
Paul Yost, M.D.   **Date**

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WE ARE CALOPTIMA

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

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

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

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

Our Values — CalOptima CARES

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

Accountability: We were created by the community, for the community, and are accountable to the community. Meetings open to the public are:~~Our~~ 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, ~~Quality Assurance Committee and Finance and Audit Committee meetings are open to the public~~and Whole-Child Model Family Advisory Committee.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.
- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.
-

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

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

We are "Be-tte-r. Togeth-er."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, Sstate and fFederal 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
CalOptima's 2017–19 Strategic Plan honors our long-standing mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

Strategic Priorities:
- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

Building Blocks:
- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long-term financial strength.

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

The five Strategic Priorities and Objectives are:
- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CalOOPTIMA?
Our Unique Dual Role

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

As both, CalOptima must:
- Provide quality health care to ensure opti~~mon~~al 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. ~~For more than 20 years, CalOptima has been serving~~ Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population. ~~Due to the implementation of the Affordable Care Act — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima grew by an unprecedented 49% between 2014 and 2016!~~

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

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

Certain services are not covered by CalOptima, but may be provided by a different agency, including those indicated below:
- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.

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

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

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, the Department of Health Care Services (DHCS) integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members into the scope of benefits provided by CalOptima. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. –

These integrated LTSS benefits include three programs:
- Community-Based Adult Services (CBAS)

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

OneCare ~~(HMO SNP)~~

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

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

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

OneCare Connect

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

These members often frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

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

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

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

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, and 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, and gym benefits, over-the-counter medication benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

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

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

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

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietiteians, 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 participantstes. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVESPROGRAM INITIATIVES

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by Department of Health Care Services (DHCS) as part of California's Medi-Cal 2020 2017–2019 sStrategic pPlan.: IiIn Orange County, the pilot is being the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. Thein 2019, the WPC Connect information sharing platform was launched in November 2018. For 20192020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

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. Currently, CCS services are carved out (separated) from most Medi-Cal managed care plans, including CalOptima. In Orange County, OC HCA manages the local CCS program. OC HCA provides case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.

As of July 1, 2019, tThrough SB 586, the Sstate has required CCS services to become a CalOptima Medi-Cal managed care plan benefit in select counties. The goal of this transition wasis to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. This approach is known as Tthe Whole-Child Model (WCM)

successfully transitions to CalOptima in 2019. -Under this model,program in Orange County, medical eligibility determination processes, and the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

~~, while other CCS program components are transferred to CalOptima. CalOptima had~~

originally expected to launch WCM effective January 1, 2019, but recently DHCS delayed the WCM implementation in Orange County, and the new implementation date is now no sooner than July 1, 2019.

Health Homes Program (HHP)

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

CalOptima planneds to implement HHP in the following two phases: July January 1, 2020,19 for members with chronic physical conditions or substance use disorders (SUD), and January July 1, 2020,- for members with serious mental illness or Serious Emotional Disturbance (SMI).

DHCS CalOptima's goal is to targeting the highest-risk 3–5 percent% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. DHCS sendswill send a targeted engagement list of members to CalOptima for review and outreach, as appropriate. To be eligible, members must have:
1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions; and
2. Meet specified acuity/complexity criteria.

Members eligible for HHP must consent to participate and receive HHP services. CalOptima will be the Lead Administrative Entity and is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary health homeHHP providers. In addition to CalOptima's Community Network, some all health networks (HN)s will may serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:
1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a

multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community corrections connections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

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

- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provides additional respite care beyond the 90 days of recuperative care under the Whole Person Care program.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members.
- Homeless Clinical Access Program — The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.

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

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes Across Settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima has developed a comprehensive PHM Strategy, which for 2019. The 2019 PHM Strategy includes a plan of actions ftoor addressing the needs of our culturally diverse members needs across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards. released in July 2018. CalOptima's PHM Strategy aims to ensure that the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

CalOptima's The 2019 PHM Strategy is based on numerous efforts to assess the health and well-being of ourCalOptima 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.

The PHM strategy plan of action addresses the unique needs and challenges of specific ethnic

communities including economic, social, spiritual, and environmental stressors, to improve health outcomes.

In the first year, the PHM Strategy will be focused on expanding the Model of Care 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. CalOptima added the PHM Value Based Payment Arrangement as the foundation to align the future Pay for Value program methodology.

WITH WHOM WE WORK CALOPTIMA'S PROVIDER NETWORKS:

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to providinge health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct-Administration and/or CalOptima Community Network (CCN) and/or contract with a CalOptima health network (HN)., and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose CCN or one of 134 HNs, representing more than 8,500 practitioners.

Health Networks (HN)

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

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to more than 1,600 Primary Care Providers (PCPs), more than 6,700 specialists, 23 hospitals, 23 clinics and 100 long-term care facilities.

CalOptima Direct (COD)

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

CalOptima Direct-Administrative (COD-A)

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

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN N

is administered internally by CalOptima and available for members to select, supplementing the ~~existing~~ HN delivery model and creating additional capacity for growth.

~~The following are CalOptima's contracted health networks:~~
CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:
- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

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

Health Network/Delegate	Medi Cal	One Car	OneCare
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:
- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

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MEMBERSHIP DEMOGRAPHICS~~MEMBERSHIP DEMOGRAPHICS~~

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2020

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

Membership Data as of November 30, 2019

Total CalOptima Membership

755,539

Program	Members
Medi-Cal*	739,601
OneCare Connect	14,065
OneCare (HMO SNP)	1,498
Program of All-Inclusive Care for the Elderly (PACE)	375

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

Member Age (All Programs)

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

Languages Spoken (All Programs)

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

Medi-Cal Aid Categories

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

CalOptima
A Public Agency
Better. Together.

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

Membership Data as of October 31, 2019

Total CalOptima Membership

743,465

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

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

Member Age (All Programs)

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

Languages Spoken (All Programs)

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

Medi-Cal Aid Categories

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

UTILIZATION ~~Utilization~~ MANAGEMENT ~~anagement~~ PROGRAM ~~rogram~~

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for ~~to~~ review of health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, NCQA Standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse ~~benefit~~ determination is made based on Medical Necessity and/or ~~coveredm~~benefit coverages ~~availability~~.
- Identify and refer high-risk members to Case Management Programs, including Complex Case Management, ~~Long-Term Services and Supports (~~LTSS~~)~~, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promote improved member health and well-being by coordinating services with appropriate

county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health and CCS.

- Educate practitioners and other providers, including delegated HNs, on CalOptima's UM Program, policies and procedures.

- Monitor utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.

UM Program Structure

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

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA) and NCQA at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

The organization chart and the UM Program's committees reporting structure reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:
- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures. (GG.1508: Authorization and Processing of Referrals; Attachment A, Timeliness of UM Decisions and Notifications.)

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:
- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs utilization managementUM activities by the Audit and Oversight

department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and program requirements.

- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

Long-Term Services and Supports (LTSS)
CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:
- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  o Nursing Facility Level B (NF-B)
  o Nursing Facility Level A (NF-A)
  o Subacute Adult and Pediatric
  o

- ~~Intermediate Care Facility/Developmentally Disabled, (ICF/DD)~~
- ~~Intermediate Care Facility/Developmentally Disabled-Habilitative, (ICF/DD-H)~~
- ~~Intermediate Care Facility/Developmentally Disabled-Nursing, (ICF/DD-N)~~
- 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.

Home- and Community-Based Services:
- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT).
- 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.

Behavioral Health Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. ~~Mental Behavioral~~ Behavioral ~~h~~Health (BH) services include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger that meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific timeframe. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) (formerly Screening, Brief Intervention, and Referral to Treatment [SBIRT]) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

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CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits including ~~utilization management~~UM, claims, credentialing the provider network, member services~~,~~ and ~~quality improvement~~QI.

OC and OCC

CalOptima ~~has~~ previously contracted with Magellan Health Inc.~~,~~ to directly manage the ~~mental health~~BH benefits for OC and OCC members. Effective 1/1/2020, OC~~/~~ and OCC covered ~~behavioral health~~ BH services ~~will be~~were full~~ing~~y integrated within CalOptima internal operations.~~ Functions delegated to Magellan include provider network, UM, credentialing, and customer service.~~ OC and OCC members can access ~~mental health~~BH services by calling the CalOptima Behavioral Health Line. Members will be connected to CalOptima representative for ~~behavioral health~~BH assistance.

~~CalOptima OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. By selecting the OC or OC C option, the member will be transferred to a Magellan representative for a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within Magellan Health Inc. provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.~~

CalOptima offers ~~Alcohol Misuse Screening and Counseling (~~AMS~~AC)~~ services in the PCP setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Linkages with Community Resources

In addition, CalOptima provides linkages with community programs to members with special health care needs, or high risk or complex medical and developmental conditions. These linkages are established through special programs, such as the CalOptima Community Liaisons, PCCs, ~~Behavioral Health~~BH Integration (BHI), ~~Long-Term Services and Supports (~~LTSS~~)~~ and specific program contracts and MOUs with other community agencies and programs, such as the OC HCA's CCS, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors
The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

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

The responsibility for the direction and management of the UM Program has been delegated to ~~the Chief Medical Officer~~ (CMO~~)~~. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

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

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to review and make recommendations to the Board regarding accepting the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC also makes recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim ~~moving upstream~~ expanding on ~~from~~ the CMS' Triple Aim:
1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

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

The MAC membership is composed of representatives from the following constituencies:
- Adult beneficiaries
- Children

- Consumers
- Family support
- Foster children
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

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

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

The OCC MAC membership is comprised of representatives from the following constituencies:
- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
  - OC SSA
  - OC Community Resources Agency, Office on Aging
  - OC HCA, Behavioral Health
  - OC IHSS Public Authority

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

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

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

Whole-Child Model Family Advisory Committee
In 2018, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning WCM, 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 WCM. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:
- Family representatives: 7–9 seats
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are a current recipient of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats

- o   Community-based organizations; or
- o   Consumer advocates

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

Role of CalOptima Officers for ~~Quality Improvement~~UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

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

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

Chief Medical Officer (CMO), along with the Deputy Chief Medical Officer (DCMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members.
~~The CMO, along with the Deputy Chief Medical Officer (DCMO)   or physician designee   oversees CalOptima's UM Program, including the strategies, programs, policies and procedures related to CalOptima's medical care delivery system.~~ At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

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

Executive Director, Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Case Coordination, Complex Case Management, and Managed ~~Long- Term Services and Support~~LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO, DCMO and the ~~Executive Director~~ED, ~~Quality & Analytics (ED of Q&A~~ of Quality and Population Health Management (Q&PHM~~)~~), makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational

efficiencies consistent with CalOptima's strategic plan, goals and objectives. The ED of C-O is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Medical Director, Utilization Management, is appointed by the CMO and/or DCMO, and is responsible for the direction of the UM Program objectives, as well as evaluation of the UM Program to drive the organization's mission, strategic goals and processes to provide high quality care to CalOptima members in a compassionate and cost-effective manner. The Mmedical

director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The ~~M~~medical ~~D~~director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the ~~Medical~~ medical ~~Director~~ director ~~of UM~~ also provides supervisory oversight and administration of the UM Program ~~. In this role, the Medical Director~~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. ~~Medical Director of UM p~~Provides clinical education and in-service~~s~~ training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The ~~M~~medical ~~D~~director of UM ensures physician availability to staff during normal business hours and on-call after hours. ~~He or she~~Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the bi-weekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

Medical Director, Behavioral Health is the designated behavioral healthcare practitioner in the QI and UM programs, and serves as a participating member of the UMC, QIC and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and ~~behavioral health~~BH care services for CalOptima members. ~~The Medical Director provides c~~Clinical oversight is also provided for ~~behavioral health~~BH benefits and services provided to members. The ~~M~~medical ~~D~~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 ~~behavioral health~~BH outcomes. ~~The Behavioral Health~~Additionally, the ~~M~~medical ~~D~~director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (~~OneCare~~ OC and ~~OneCare Connect~~OCC), ~~Managed LTSS~~ (MLTSS~~)~~ programs, Case Management and Transitions of Care programs. The ~~M~~medical ~~D~~director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The ~~M~~medical ~~D~~director works in collaboration with the other ~~M~~medical ~~D~~directors and the clinical staff within ~~Population Health Management~~PHM, ~~Grievance and Appeals~~GARS, and Provider Relations. The ~~M~~medical ~~D~~director works closely with the nursing and non--clinical leadership of these departments.

Medical Director, Population Health Management/, Health Education/, Program for All Inclusive Care for the Elderly (PACE) ~~Programs~~ is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, disease management and health education programs, while also providing clinical quality oversight of the PACE- Center~~Program~~.

Director, Utilization Management
Director is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. This position will provide leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima's Utilization Management program for CalOptima Community

Network, CalOptima Direct and the delegated health networks. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.
is responsible for directing and coordinating the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental activities. The director develops and implements the UM Program, and UM Work Plan, maintains and updates policies, procedures and work flowsworkflows to meet regulatory, contractual and accreditation standards.

Director, Behavioral Health Services provides operational oversight for behavioral healthBH benefits and services provided to members. The director is responsible for monitoring, analyzing, and reporting to senior staff on changes in the health care delivery environment and program

 opportunities affecting or available to assist CalOptima in integrating physical and behavioral healthBH care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, and executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

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

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

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

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The directors ensures that CalOptima and its subcontracted health networkHNs perform consistently with both CMS and state requirements for all programs. Specifically, the directors 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 directors are responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. These positions interact with the Board of Directors, CalOptima executives, departmental management, HN management and Legal Counsel.

UM Resources

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

Manager, Utilization Managementr (Concurrent Review Manager [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops,

implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2-–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (C~~Concurrent~~ Review) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training ~~and in-servicing~~ activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with ~~company~~ CalOptima policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in Utilization Management activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as

regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training ~~and in-servicing~~ activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education
- Current and unrestricted RN license or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action Medical Case Managers (RN/LVN)RNs draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education
- Current and unrestricted California Board LVN or CA RN license.RN in the State of California
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs; and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- Current and unrestricted California Board LVN or RN license.
- Minimum of 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case

Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

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

Experience & Education
- High school diploma or equivalent; a minimum of 2 years of college preferred.
- 2–3 years previous administrative experience preferred. Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.
-

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the third-party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies, and pharmacy organizations.

Experience & Education
- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The

Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T), Committee (P&T), interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education
- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years' experienceyears' experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy Ddirector 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 Networks and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education
- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years of² experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education
- Pharm.D degree from an accredited college of pharmacy.
-

- Eligibility for licensure in California.

PBM (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. CalOptima pharmacists with a current license to practice without restriction and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF/ICF-DD/N/H) and other LTSS services.

Experience & Education
- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including five 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that services standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networkHNs, and other internal and external customers in a professional and competent managermanner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTC LTSS services.

Experience &and Education
- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health with geriatrics and persons with disabilities.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include:include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Experience &and Education
- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, NCQA standards, and Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and acts as liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience &and Education
- A current and unrestricted RN license or LVN license in the State of California or a current unrestricted LVN license in the State of California.
- Minimum of 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.
-

Program Manager, ~~CBAS~~ LTSS is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. This position is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviewing the monthly files audit, developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Experience & Education
- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required.
- Masters preferred.
- Minimum of 3 years CBAS and program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office (approximately 5% of the time or more will involve traveling to CBAS centers and community events).

Behavioral Health Integration ~~(BHI)~~ Resources

The following staff positions provide ~~utilization management~~UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for ~~managing behavioral health treatment (BHT) services, including applied behavior analysis (ABA), for members that meet medical necessity criteria. The manager oversees care managers who review assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The manager designs and implements processes to ensure effective delivery of BHT services.~~ overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and ~~Behavioral Health Treatment (~~BHT~~)~~ services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as ~~This position~~ collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education
- Master's degree in Behavioral Health or other related degree is required.
- A current and unrestricted ~~Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.~~
- Licensed Clinical Social Worker (~~(~~LCSW)~~,~~ or Licensed Marriage and Family Therapist (~~-~~LMFT) license in the State of California required~~, Licensed Psychologist)~~ is preferred.
- 4~~+~~ years of supervisor or manager level experience ~~in clinical management of ABA services is~~

required.
- 1 year 3+ years of experience providing ABA therapy to children diagnosed with ASD is required.
- Eexperience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).
- 1-year eExperience in developing policies and procedures to meet federal and state regulatory requirements.
- 1-year experience in developing sound and responsible business plans and financial models preferred.

Program Manager, Sr. (Behavioral Health) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing behavioral healthBH utilization managementUM goals and activities. The position works under the direction of the Director, of Behavioral Health Services (Integration), Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities.

Experience & Education
- Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.
- 4 years' of experience working in a managed care environment, with specific experience in behavioral health utilization managementBH UM.
- 4 years of supervisor or manager level experience required.
- Experience in a government or public environment strongly preferred.
- 2 years of' experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.
- 2 years' of experience and aptitude for working in a highly matrixed, mission-driven organization required.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The Supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The Supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures. ~~UM is responsible for the UM functions within the BHI department. The supervisor monitors and oversees the department's UM work activities to ensure that member's behavioral health service needs are coordinated with medical service requests, and service standards are met. The supervisor serves as a resource to staff regarding CalOptima policies and procedures and is responsible for regulatory requirements governing authorization processing and monitoring utilization patterns. The position directly supervises the medical case managers.~~

> Experience & Education
> - Master's degree in Behavioral Health or other related degree is required.
> - Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
> - 3~~+~~ or more years of supervisor level experience in clinical management of ABA services is required.
> - 3~~+~~ or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.

~~Experience & Education~~
- ~~Graduate of an accredited School of Nursing or bachelor's degree in behavioral health related area required.~~
- ~~Current and unrestricted California Board Licensed RN or LCSW required.~~
- ~~Minimum of 3 years of behavioral health experience.~~
- ~~Minimum of 3 years of supervisory experience, preferably in a managed care setting.~~
- ~~Strong written and analytical skills required.~~
- ~~Experience with ABA preferred~~

Medical Case Managers (~~RN Behavioral~~ Health) are responsible for clinical review and recommendations related to Interdisciplinary Care Team (ICT) meetings, inpatient and outpatient psychiatric authorization requests from ~~Behavioral Health~~BH providers and completing inpatient ~~Concurrent Review (~~CCR~~)~~ and transitional care for ~~OneCare/OneCare Connect~~OC and OCC members. They are responsible for adhering to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity, consulting with the ~~M~~manager~~,~~ and ~~CalOptima~~ Medical Director as needed. They also review prior authorization requests for outpatient mental health services.

~~are responsible for the oversight and review of ABA services offered to members that meet the medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from behavioral health providers. This position is also responsible for utilization management 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. The position is also responsible for reviewing and processing authorizations for psychological testing.~~

> Experience & Education
>
> - Current and unrestricted RN license to practice in the State of California ~~and a~~
> - ~~m~~Minimum of ~~three (3)~~ years current ~~behavioral health~~BH clinical experience or an equivalent combination of education and experience required.

- Active Certified Case Manager (CCM) certification preferred.
- Experience in a prior authorization and/or managed care environment preferred.
- Experience with inpatient concurrent review strongly preferred.
  ~~Current LVN/RN license to practice in the State of California and a minimum of three (3) years current clinical experience or an equivalent combination of education and experience required.~~

Medical Case Manager (~~LVN – B~~ehavioral ~~H~~ealth) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. Utilizes ~~CalOptima's~~ medical criteria, policies, and procedures to authorize referral requests from ~~behavioral health~~BH professionals, clinical facilities and ancillary providers

Experience & Education
- High school diploma required, Associates or ~~b~~Bachelor's degree in related field preferred
- Current and unrestricted LVN license to practice in the State of California required
- 3 years of clinical experience required
- Inpatient behavioral health experience preferred
- Active CCM certification preferred

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from ~~behavioral health~~BH providers. This position is also responsible for ~~utilization management~~UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Experience & Education
- Master's degree in Behavioral Health or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or ~~Board Certified~~Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.
- 4+ or more years providing ABA therapy to children diagnosed with ASD is required.
- ~~Possess~~ Experience ~~clinical~~in clinical, medical utilization review, and/or quality assurance ~~experience~~ is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the ~~behavioral health~~BH system of care. This position will act as a consultative liaison to assist members, ~~health network~~HNs and community agencies to coordinate BHT services.

Experience & Education
- High school diploma or equivalent is required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's ~~L~~license and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

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

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:
- CalOptima New Employee Orientation.
- HIPAA and Privacy/Corporate Compliance.
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.).
- UM Program, policies/procedures, etc~~.~~
- MIS data entry.
- Application of Review Criteria/Guidelines.
- Appeals Process.
- Seniors and Persons with Disabilities Awareness Training.
- ~~OneCare~~ OC and ~~OneCare Connect~~OCC Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health 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. AUM 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 behavioral healthBH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff is required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2020 ~~COMMITTEE~~ Committee Organization ~~STRUCTURE~~Structure — Diagram
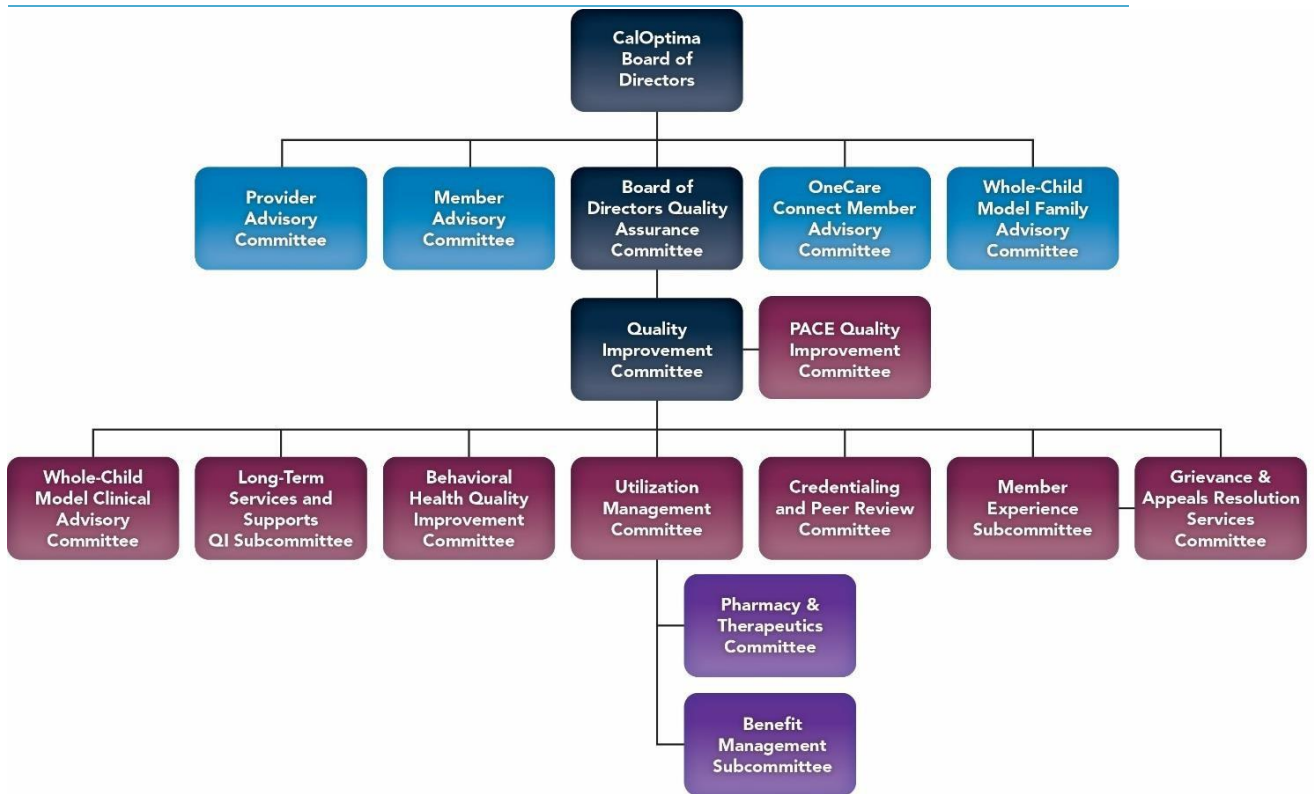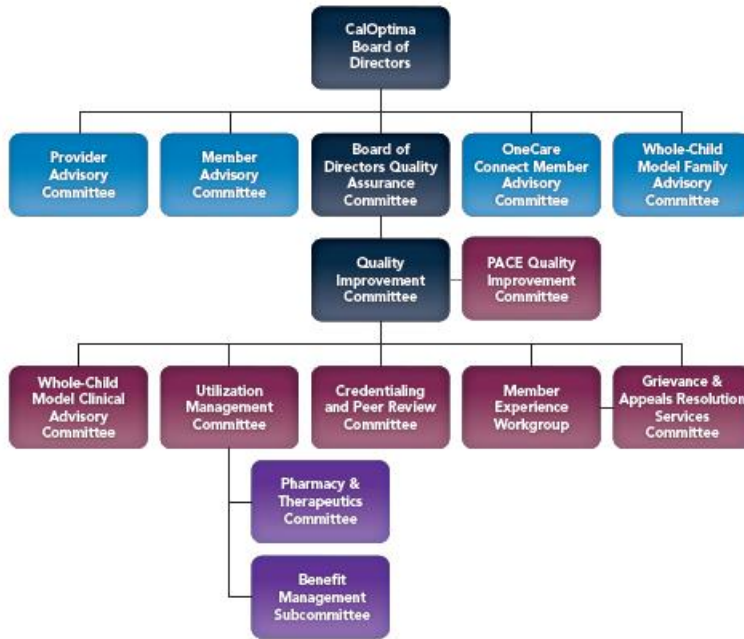
Utilization Management Committee (UMC)

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

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, and SRGs, and MBHOs 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 and Work Plan, and also 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 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 ~~through CalOptima's~~to QIC and ultimately to ~~CalOptima's~~ QAC and the Board of Directors.

UMC Scope and Responsibilities
- Provides oversight and overall direction for the continuous improvement of the ~~utilization management~~UM program, consistent with CalOptima's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima and its delegated HN.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the ~~utilization management~~UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria~~, UM Work Plan~~, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; ~~R~~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 under/over utilization monitoring in accordance with UM Policy and Procedure GG.1532 Over and Under Utilization Monitoring; ~~sets appropriate upper and lower thresholds for over/under utilization trend reports.~~makes recommendations for improving performance on identified over-/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:
  Direct Subcommittee Reports:
    - Benefit Management Subcommittee (BMSC)
    - P&T
  Departments Reporting Relevant Information on UM Issues:
    - Delegation Oversight
    - Behavioral Health
    - Grievance and Appeals
    - UM Workgroup
    - LTSS
- Reports to the QIC on a quarterly basis; communicates significant findings and makes recommendations related to UM issues.

UMC Membership
Voting Members:
- CMO
- Medical Director UM
- Medical Director Behavioral Health*
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Up to sSix participating practitioners from the community**

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

** Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists, and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:
- Director, UM
- Medical Director, Whole Child Model
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division (MMCD), All Plan Letters (APLs), and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:
- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership
The subcommittee membership consists of the following:
- Medical Director, Utilization Management — Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
-

- Director, Coding Initiatives

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Behavioral Health Quality Improvement Committee (BHQIC)

The purpose of the BHQIC is to:

Ensure members receive timely and satisfactory behavioral health care services.

Enhance the integration and coordination between physical health and behavioral health care providers.

Monitor key areas of service utilization by members and providers.

Identify areas of improvement.

Guide CalOptima towards the vision of bi-directional behavioral health care integration.

BHQIC Scope

The BHQIC responsibilities are to:

Ensure adequate provider availability and accessibility to effectively serve the membership.

Oversee the functions of delegated entities.

Monitor to ensure that care rendered is based on established clinical criteria, and clinical practice guidelines, and complies with regulatory and accrediting agency standards.

Ensure that member benefits and services are not underutilized, and that assessment and appropriate interventions are taken to identify inappropriate over utilization.

Utilize member and network provider satisfaction study results when implementing quality activities.

Maintain compliance with evolving NCQA accreditation standards.

Communicate results of clinical and service measures to network providers.

Document and report all monitoring activities to appropriate committees.

BHQIC Members

The designated chairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible for reviewing information, reporting findings, and making QI recommendations, and represents the BHQIC at the QIC meetings. The voting members of the BHQIC include:

CMO

Executive Director, Clinical Operations

Medical Director, Behavioral Health Integration

Director of Behavioral Health Services

Medical Director, Medical Management

Medical Director, UM

Executive Director, Quality and Analytics

Medical Director, OC HCA

Medical Director, Managed Behavioral Health Organization

Medical Director, Health Network

Medical Director, Regional Center of Orange County

The committee may permit participation by other CalOptima staff or outside guests with relevant expertise and experience. The BHQIC meets quarterly at a minimum, and more frequently as needed.

LTSS Quality Improvement Subcommittee (LTSS QISC)

The LTSS QISC was created to provide a forum for LTSS providers to share best practices, identify challenges and barriers, and identify solutions that are person-centered, maximize available resources and reduce duplication of services.

The LTSS QISC Purpose

The purpose of the LTSS QISC is:

Engage stakeholders on strategies for integrating LTSS programs within the managed care delivery system.

Improve coordination of care for CalOptima members who reside in long-term care facilities and for those who receive Home- and Community-Based Services (HCBS).

The LTSS QISC Responsibilities

The LTSS QISC responsibilities are to:

Identify barriers to keeping members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and prevent inappropriate admissions.

Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, MSSP and other HCBS.

Monitor the important aspects of quality of care, quality of services and patient safety by collecting and analyzing results.

Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.

Identify and recommend topics for LTSS provider workshops, educations and

trainings.

The LTSS QISC Structure

The designated chairman of the LTSS QISC is the Medical Director, Senior Programs, and the LTSS QISC invites the following participants:

Nursing Facility Administrators

CBAS Administrators

OC SSA, Deputy Director or Designee

MSSP, Site Director or Designee

CMO

Medical Director, QI and Analytics

Medical Director, UM

Executive Director, Clinical Operations

Executive Director, Quality Analytics

Manager(s), LTSS

Director, LTSS

The LTSS QISC meets at least quarterly, and as needed.

~~INTEGRATION WITH THE QUALITY IMPROVEMENT PROGRAM~~Integration with the QI Program

The UM Program ~~and Work Plan are~~ is evaluated and submitted for review and approval annually by ~~the CalOptima~~ UMC, ~~the~~ QIC and ~~the~~ QAC, with final review and approval by the Board of Directors.

- The UM program is evaluated, revised and prepared for approval by the UM Director in conjunction with the Executive Director of Clinical Services, Chief Medical Officer, Deputy Chief Medical Director and Utilization Management Medical Director prior to submission for committee review and approval.
- Utilization data is collected, aggregated and analyzed including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, Managed LTSS Programs, P&T, QI, Credentialing, Compliance, and Audit and Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate

potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on ~~utilization management~~UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Confidentiality

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

All records and proceedings of the QIC and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All

information is maintained in confidential files. The HMOs, PHCs, and SRGs and Managed Behavioral Health Organizations (MBHOs) 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.

Integration With Other Processes

The UM Program, Case Management Program, Behavioral Health Program, Managed LTSS Programs, P&T Committee, Quality Improvement, Credentialing, Compliance, and Audit and Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to **CalOptima's QI department. As case managers perform the** functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the u**tilization of services is inter-related with the quality and outcome of the services.**

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non- covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

Early childhood intervention
State protective and regulatory services
Women, Infant and Children Services (WIC)
EPSDT Health Check
Services provided by local public health departments

UM PROCESS

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization 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, or scheduled inpatient services. The process is complete when the requesting practitionepractitioner r

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 ~~the Centers for Medicare and Medicaid Services (~~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 ~~CalOptima~~ Audit and Oversight department via its delegation oversight team for compliance.

~~UM Program Structure~~

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

~~The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, DMHC, CDA and NCQA at least annually. Recommendations for revisions and improvements are made, as appropriate. The UM Work Plan is based on the findings of the annual program Work Plan evaluation. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.~~

~~Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.~~

~~The organization chart and the~~ UM ~~pP~~rogram's ~~Cc~~ommittee's reporting structure accurately reflect ~~CalOptima's~~ 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 UMC and QIC, which serve as the oversight committees for CalOptima UM functions, are contained and delineated in the ~~Cc~~ommittee's ~~Cc~~harters.~~

~~The CalOptima UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the UM Program and UM Work Plan.~~

REVIEW~~EVIEW~~ ~~AND~~AND AUTHORIZATION~~UTHORIZATION~~ ~~OF~~OF ~~SERVICES~~ERVICES

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances, relative to appropriate clinical criteria and CalOptima policies, applying current evidence-based guidelines, and consideration of available services within the local delivery system. These decisions are consistent with current evidence-based clinical practice guidelines.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with ~~the Centers for Medicare and Medicaid Services~~CMS and the State of California for Medi-Cal, OC and OCC. Medically necessary means ~~all covered services or supplies that~~:

- For Medi-Cal, covered services that ~~aA~~re reasonable and necessary to protect life, prevent ~~significant~~ illness or ~~significant~~ disability, ~~or to~~ alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, 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 member under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code sections 14132(v).
  - ~~Meet the standards of good medical practice in the local area;~~
  - ~~Are consistent with current evidence-based clinical practice guidelines; and~~ .
- ~~Are not mainly for the convenience of the member or the doctor.~~
- For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in ~~other~~ appropriate ~~health care~~situations, ~~professionals,~~ review and determine all final denial or modification decisions for requested medical and ~~behavioral health~~BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified ~~P~~physician or ~~P~~pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:
- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization inpatient review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for health network members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications, or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
  - Age
  - Co-morbidities
  - Complications
  - Progress of treatment
  - Psychological situation

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- o Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure GG.1508, Authorization and Processing of Referrals.
- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (or Peer-to-Peer), or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not ─limited to:
- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information

- Information from responsible family members

CalOptima's UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by providers and processed electronically. Some referrals are auto -adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, -and all non-emergency out-of- network practitioners
t.

Second Opinions
A second opinion may be requested when there is a question concerning diagnosis or options for

surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in--network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "Standing Referral" policy and procedure, Standing Referral: GG.1112, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process
The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. members by UM decision makersCalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT
Pharmacy Management is overseen by the CMO, and CalOptima's Director, Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by the P&T Committee and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The CalOptima P&T Committee is responsible for development of the CalOptima Approved Drug List (Formulary), which is based on sound clinical evidence, and is reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers. If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate, and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's PBM for review. All potential authorization denials are reviewed by a Ppharmacist at CalOptima, as per DHCS requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a Cclinical Ppharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

PHARMACYharmacy DETERMINATIONSeterminations

Medi-Cal
CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the CalOptima P&T Committee. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima pharmacist or Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima pharmacist or Medical Director. CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.

OC/OCC
CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Formulary
The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the ~~CalOptima~~ P&T ~~Committee~~. Final approval from the P&T ~~Committee~~ must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.

Pharmacy Benefit Manager
The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, ~~customer service,~~ pharmacy help desk, prior authorization, clinical services and quality improvement functions. ~~The PBM recommends denial decisions based on lack of medical necessity, drugs not included in the Formulary, prior authorization not obtained, etc.~~ The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBM is monitored according to the Audit and Oversight department's policies and procedures.

B~~EHAVIORAL~~EHAVIORAL H~~EALTH~~EALTH D~~ETERMINATIONS~~ETERMINATIONS

Medi-Cal
CalOptima's ~~Behavioral Health Integration~~BHI department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by ~~behavioral health~~BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, APL, and CalOptima policy (approved by DHCS).

OC/OCC
CalOptima has previously delegated Magellan Health Inc. to directly manage the behavioral health utilization management functions for OneCare/OneCare Connect. Effective ~~1/1/~~January 1, 2020, CalOptima's ~~Behavioral Health Integration~~BHI ~~D~~department will perform prior authorization review functions for OC/OCC covered behavioral health services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, and psychological testing. Prior authorization requests are reviewed by ~~behavioral health~~BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL), and CalOptima policies.

The ~~behavioral health~~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 ~~Licensed~~ Psychologist or Medical Director. CalOptima's written notification of ~~behavioral health~~BH modifications and denials to members and their treating practitioners contains:
- A description of appeal rights, including the member's right to submit written comments,

documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent

denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss ~~behavioral health~~BH UM denial decisions.

~~OC/OCC~~
~~CalOptima delegates Magellan Health Inc. to directly manage the behavioral health utilization management functions for OneCare/OneCare Connect. Magellan complies with regulatory timelines and criteria set forth by MCG guidelines, APL's, and CalOptima Policies (approved by CMS).~~

UM C~~RITERIA~~RITERIA
CalOptima conducts Utilization Review using UM criteria that are nationally recognized, evidence-based standards of care and include input from recognized experts in the development, ~~adaption~~ 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:

MEDIedi-CALal

1. Federal and Sstate lLaw Mmandates (i.e. Centers for Medicare and MedicaidS, Department of HealthCare ServicesDHCS);
2. Medi-Cal Manual of Criteria/ and Medi-Cal Benefits Guidelines
3. EPSDT
4. Nationally recognized Eevidence Bbased criteria such as Milliman Care Guidelines (MCG), –U.S. ®Preventative Services Task Force Recommendations, and National Comprehensive Cancer Guidelines, etc.
5. Transplant Centers of Excellence guidelines
6. Preventive health/ and/or Ssociety guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology ([ACOG] Guidelines), American Medical Association (AMA), and National Guidelines Clearinghouse)
   — BHCalOptima Policy & Procedures and/or Clinical Benefits & Guidelines
7.

WHOLEhole CHILDhild MODELodel (MEDI CAL)

In addition to the Medi-Cal hierarchy above:
— CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to CCS and Whole Child Model.
1.

MEDICAREedicare (OneCare and OneCare Connect)

For OC and OCC:

1. Federal and Sstate Llaw Mmandates (i.e. Centers for MDedicare and Medicaid, Department of HealthCare ServicesDHCS);
2. CMS Guidelines Local and National Coverage Determinations (LCD, NCD);
3. Medicare Part D: CMS-approved Compendia (for medications)
4. Medi-Cal Manual of Criteria/ and Medi-Cal Benefits Guidelines
5. Nationally recognized Eevidence Bbased criteria such as MCG, UpToDate, U.S. Preventative Services Task Force Recommendations,- and National Comprehensive Cancer Guidelines, etc.
6. Transplant Centers of Excellence guidelines
7. Preventive health and/or /sSociety guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines,) American Medical Association, National Guidelines Clearinghouse)
8. CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines

- Nationally-recognized Evidence Based criteria such as Milliman Care Guidelines (MCG)
- Medicare and Medi-Cal Manuals of Criteria
- Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) guidelines
- Medicare Part D: CMS-approved Compendia
- National Guideline Clearinghouse
- National Comprehensive Cancer Network (NCCN) Guidelines
- Transplant Centers of Excellence guidelines
- Preventive health guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines)
- CalOptima Criteria for outpatient behavioral health services
- CalOptima Policies and Medi-Cal Benefits Guidelines

- ~~Beginning July 1, 2019, or such later time as CalOptima assume responsibility for the provision of CCS services for its members, CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to CCS and Whole Child Model.~~

Delegated ~~health network~~HNs must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case- specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes,

Lead Screening, Immunizations, and ADHD/ADD Gguidelines for both adults and children.

Authorization Types

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	PA UM Nurse Reviewer**	Medical Director/ /Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy Ddepartment	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Inpatient hospital services	MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals		X	

Transplants	DHCS Guidelines/ MCG		X	X

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	PA Nurse Reviewer**	Medical Director /Physician Reviewer (Denials and Modifications)
~~Transplants~~	~~DHCS Guidelines/ MCG~~		X	X

~~Long-Term Support Services Authorization Types~~Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		X	X
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		X	X
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		X	X
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51003 and 51303		X	X
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51343 and 51164	X DDS or DMH Certified	X	X
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	X	X	X

~~Medi-Cal~~ Behavioral Health Services ~~Authorization Types~~

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	**X**		**X**
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	**X**	**X**	**X**

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, ~~behavioral orhealth~~BH, or certain appeal reviews, the clinical judgment needed for a~~n~~ UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified ~~behavioral health~~BH professionals as determined by the Medical ~~Director, for~~Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

~~For the purposes of Behavioral Health review and oversight as a delegated vendor, Magellan ensures there are peer reviewers/clinical consultants. Peer reviewers are behavioral health professionals who are qualified, as determined by Magellan's Medical Director, to render a clinical opinion about the behavioral health condition, procedure, and/or treatment under review. Peer reviewers must hold a current unrestricted California license to practice medicine in the appropriate specialty to render an opinion about whether a requested service meets established medical necessity criteria.~~

New Technology Review

~~Medi-Cal, OC and OCC~~
~~CalOptima's~~ The P&T ~~Committee~~ and ~~Benefit Management subcommittee~~BMSC shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for members, in accordance with CalOptima Policy GG.1534 Evaluation of New Technology and Uses.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting ~~CalOptima's~~ the UM department or may discuss the UM decision

with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies with regard to UM timeliness of decisions. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability (IRR)

At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director,

Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, CalOptima's UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the committee.

Provider/ and Member Communication

Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing or speech impaired members are available toll free at **800-735-2929**. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, or faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (behavioral healthBH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling CalOptima's main toll

free phone number and asking for the CalOptima Medical Directorthe direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care, our UM system.

UM Staff Access to Clinical Expertise
The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records
UM staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required to validate medical necessity for the requested service. when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay during a verbal review. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information
CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g. discharge planning, case management, disease management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider/ Communication to Member Communication
CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:
- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment.
-
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
-

TIMELINESS TIMELINESS OFOF UM DECISIONSECISIONS
UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for

providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

Medi-Cal (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Routine (Non-Urgent) Pre-Service: Prospective or concurrent service requests where no extension is requested or needed	Approve, modify or deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances but no later~~longer~~ than 14 calendar days following receipt of request. "Aall information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.

| Routine (Non-Urgent) Pre-Service

Extension Needed
(AKA: Deferral)
• Additional clinical information required
• Requires consultation by an expert reviewer
• Additional examination or tests to be performed | Due to a lack of information, for an additional 14 calendar days, under the following conditions:
▪ The member or the member's provider may request for an extension, or the plan can provide justification upon request by the Sstate for the need for additional information and how it is in the member's interest. The delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.

Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. | **Practitioner:**
Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request | **Practitioner:**
Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request.

Member:
Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request

Note: CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay. |

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
	Additional Requested Information is Received: A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.		
Expedited Authorization Requests (Pre-Service): No extension requested or needed. All necessary information received at time of initial request. Requests where a provider indicates, or the plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) — ~~Extension~~ **Extension** needed: ~~.~~ Extension is allowed *only* if member or provider requests the extension or the plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member.	The plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the plan asks the member, the member's representative, or provider for the specific information necessary to make the decision.	**Practitioner and Member:** Within 24 hours of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member

	▪ The plan gives the member or member's authorized representative at least 48 hours to provide the information.
	▪ The extension period, within which a decision must be made by the plan, begins:
	  o On the date when the plan receives the member's response (even if not all of the information is provided), *or*
	  o At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.
			Member:
			Within 2 business days of the ~~decision[2] but~~decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[3] (written notification)
			
			Note: CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

	Expedited (Urgent) Pre-Service request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met:
	▪ A request for services where application of the time frame for making routine or non-life-threatening care determinations:
	  o Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
	  o In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
		Practitioner:
		Within 24 hours of making the decision
			Practitioner:
			Within 2 working days of making the decision
			
			Member:
			Within 2 working days of making the decision

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	o The member or the member's provider may request for an extension, or the health plan/provider group can provide justification upon request by the state for the need for additional information and how it is in the member's interest. o 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. o Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the health plan's decision, and a care plan has been agreed	Within 24 hours of receipt of the request **NOTE:** The plan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the plan previously; the plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The plan has up to 72 hours to make a	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the plan must notify beneficiaries at least 10 days before the date of the action with the exception of circumstances

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
upon by the treating provider that is appropriate for the medical needs of that member	decision (NCQA UM 5). o A response to defer is required within 24 hours for all services that require prior authorization. o A decision to approve, modify, or deny is required within 72 hours, or as soon as a member's health condition requires, after the receipt of the request. o If the plan is unable to request for an extension of an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		permitted under Title 42, CFR, Sections 431.213 and 431.214.
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision [2] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May be Oral and/or Electronic)**	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request.	**Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types: Written notice within 30 calendar days from receipt of the information necessary to make the determination.
	Additional Information Received: If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Member & Practitioner**: None specified	
	Additional Clinical Information Incomplete or Not Received: Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified	
Hospice - Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

UM Decision and Notification Timelines —Medicare (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) If no extension requested or needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) If extension requested or needed	May extend up to 14 calendar days. **Note:** Extension allowed *only* if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions *must not* be used to pend organization determinations while waiting for medical records from contracted providers.	*Extension Notice:* Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: The reasons for the delay The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. *Decision Notification After an Extension:* Must occur no later than expiration of extension.
Expedited Initial Organization Determination If expedited criteria are not met	Promptly decide whether to expedite — determine if: 1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. o If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. The written notice must include: 1. Explain that the health plan will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	received for an expedited determination.	4. Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination If no extension requested or needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** o Oral or written notice must be given to member and provider within 72 hours of receipt of request. o Document date and time oral notice is given. o If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** o When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request.
Expedited Initial Organization Determination If extension requested or needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. ▪ When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).	*Extension Notice:* Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt. *Decision Notification* After an Extension: ▪ Approvals o Oral or written notice must be given to member and provider no later than upon expiration of extension. o Document date and time oral notice is given. If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials o When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be received by member and provider no later

Type of Request	Decision	Notification Timeframe Member and Practitioner
	▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	than upon expiration of extension.

~~UM Decisions and Timeframes for Determinations~~ Pharmacy for Medi--Cal, OC~~C~~ & OCC

Medi-Cal Pharmaceutical — Decision Making	O~~ne~~Care and O~~ne~~Care ~~C~~ ~~onnect~~ Pharmaceutical — Decision Making
• Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals	• Processed by CalOptima Pharmacy Management department • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals

Medi-Cal Pharmacy Timeframes for Determinations	O~~ne~~Care and O~~ne~~Care Connect Pharmacy Timeframes for Determinations (Part D):
Standard (Non-urgent) Preservice: Within 24 hours a decision to approve, modify, deny or defer is required. **Standard (Non-urgent) Preservice, Extension Needed:** Within 5 working days of receiving needed information, but no longer than 14 calendar days **Expedited (Urgent) Preservice/Concurr~~r~~ent:** Within 24 hours a decision to approve, modify, deny or defer is required. **Expedited (Urgent) Preservice/Concurrent, Extension Needed:** Within 72 hours of the initial request ~~Concurrent: A deferral must be made within 24 hours if indicated. Approval, modification or denial within 72 hours.~~ **Post-Service/Retrospective:** Within 30 days of receipt	• Routine: 72 hours • Urgent: 24 hours • Retrospective: 14 days

Medi-Cal Pharmacy Timeframes for Notification	OneCare and OneCare Connect Pharmacy Timeframes for Notification (Part D)
Routine (Non-Urgent): **Pre-Service and Concurrent Approvals:** ~~Extension Needed:~~ Provider: Electronic/written: Within 2~~4~~ ~~business hours~~days of making the decision~~, not to exceed 14 calendar days from the receipt of request~~. ~~Member: Written: Within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.~~ **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. ~~Expedited Authorization (Pre-Service):~~ ~~Notification of Denial or Modification:~~ ~~Provider: Electronic/written: Within 2 business days of making the decision.~~ ~~Member: Written: Within 2 business days of making the decision.~~ ~~Expedited (Urgent) Preservice, Extension Needed:~~ ~~Provider: Electronic/written: Within 2 business days of the decision~~ ~~Member: Written: Within 2 business days of the decision~~ ~~Concurrent:~~ ~~Provider: Electronic/written: Within 24 hours of making the decision.~~ ~~Member: Written: Within 24 hours of making the decision.~~ **Post Service/ Retrospective Approvals~~Review~~:** Practitioner: Written: Within 30 days of receipt of request. ~~Member: 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. **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 ~~a/ day~~per day, 7 days ~~a/ week~~per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Services

A ~~H~~hospital must submit a Prior Authorization Request for Post-Stabilization Services when a ~~M~~member who has received ~~E~~emergency ~~S~~services for an ~~E~~emergency ~~M~~medical ~~C~~condition is determined to have reached medical stability, but requires additional, ~~M~~medically ~~N~~necessary inpatient covered services that are related to the ~~E~~emergency ~~M~~medical ~~C~~condition, and provided to maintain, improve or resolve the ~~M~~member's stabilized medical condition.

CalOptima or a H~~ealth~~ Network shall approve or deny within 30 minutes after receiving a ~~the~~ pPrior aAuthorization rRequest for pPost- sStabilization Sservices and all information reasonably necessary and requested to render a decision from a hospital for Medi-Cal members, ~~within 30 minutes of receipt of the telephone call from the H~~hospital for Medi- Cal members, and within 60 minutes ~~of receipt~~after of receiving such request and information ~~the telephone call~~ from ~~the~~ a hospital for O~~ne~~Care or OneCare ~~Connect~~ members. If CalOptima or the HN does not respond within the prescribed time frame, ~~M~~medically ~~N~~necessary post-stabilization services are considered approved.

~~Although CalOptima may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, CalOptima does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify CalOptima of the screening and treatment within the required time frames, except as related to any claim filing time frames. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.~~

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PRIOR Prior AUTHORIZATION Authorization SERVICESServices

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director, UM or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.150008 Authorization Instructions for CalOptima Direct and CalOptima Community Network ProvidersAuthorization and Processing of Referrals.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

In addition to authorization for post-stabilization services that often result in an inpatient admission, fFacilities are also required to notify CalOptima of all inpatient admissions within 1 business day following the admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed

- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously

approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre- service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Hospitalist/SNFist Program

The goal of the Hospitalist/SNFist Program is for early identification and management of members, either in the Emergency Room or inpatient setting, with prompt linkage to an identified hospitalist/SNFist to ensure that the member receives the appropriate care in the most appropriate setting. Appropriate setting is determined by medical providers using established evidence based clinical and administrative criteria. Other program objectives include:

Initiate appropriate care plan consistent with:
- Established estimated length of stay criteria.
- Medical necessity criteria to establish appropriate level of care.
- Member psychosocial needs impacting ongoing care.
- Communication of current and ongoing needs impacting discharge planning and after-care requirements to PCP and others involved in the members care.
- Facilitation of transfer of members from non-contracted facilities to facilities with a contracted hospitalist team.

Contracted hospitalist groups, facilities case management staff, and Emergency Room personnel receive training from CalOptima staff on:
- Early identification of COD members
- Process for notification of hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care plan development and implementation
- Discharge planning

The role of the hospitalist is to work together with the Emergency Department team to determine the optimal location and level of care for the member's treatment needs. If, based on clinical information and medical necessity criteria, the member requires admission to the facility; the hospitalist assumes primary responsibility for the member's care as the admitting physician and will coordinate the member's care together with CalOptima medical management staff. If at any time the member is appropriate for transfer to a lower level of care, whether directly from the emergency room or after admission, the hospitalist will facilitate the transfer to the appropriate setting, in concert with the accepting facility and with CalOptima staff.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:
- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in GG.1508 Authorization and Processing of Referralsthe Referral/Authorization

Processing Policy and Procedure. The written notification is written in lay language that is easily understandable at the 6thth grade level and includes the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (behavioral healthBH 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 GRIEVANCE AND APPEAL PROCESSROCESS

CalOptima has a comprehensive review system to address matters when Medi-Cal, OneCare or OneCare Connect members wish to exercise their right to review a UM decision to deny, delay, or modify a request for services, or terminate a previously-approved service. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Greivance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution. The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. The appeal process is in accordance with and CalOptima Policy GG.1510: Appeal Process. This process includes:

- Collection of data. information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM -or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a

Board-

Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

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

Expedited Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt.

At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Hearing (Medi-Cal Line of Business Only)

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OneCare and OneCare Connect members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical

records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions (PPCs)

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:
1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

LONG-TERM SERVICES AND SUPPORTS

Long-Term Care

The Long Term CareLTC case management program includes authorizations for the following facilities: nurse case manager
- Skilled nursing
- NF-A and NF-BIntermediate care, sub-acute care
  o Intermediate care, developmentally disabled
  o Intermediate care, developmentally disabled – habilitative
  o Intermediate care, developmentally disabled – nursing

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, Congregate Living Health Facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. There are two types of NFs: Onsite NFs where nurses make monthly or bi-monthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either aAn on-site visit or FAX-IN process is scheduled to assess a patient'smember's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for onsite only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when member needs indicate a referral is appropriate. In addition, the LTC staff provides

education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include: health care coordination; meal service (at least one per day at

center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP

CalOptima has responsibility for the payment of the MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to:, senior center programs; case management; money management and counseling; respite; housing assistance; assistive devices; legal services; transportation; nutrition services; home health care; meals; personal care assistance with hygiene; personal safety; and activities of daily living.

Transitions of Care (TOC)

Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members discharged from Fountain Valley Regional Hospital (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:
- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a Personal Health Record (PHR) to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the 2019 Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by ~~CalOptima's~~ 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 ~~CalOptima~~ Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program~~,~~.

Coordination of Care~~.~~

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-~~caid~~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 and reported to UMC. Measures are monitored and reviewed for over and underutilization, and/or changes in trends. Actions are determined based on trends identified and evaluated for effectiveness.

The following are measures tracked and monitored for over/under utilization trends:
- ER admissions
- Bed Days
- Admits per 1000
- ~~ALOS~~Average Length of Stay
- Readmission Rates
- Denial Rates
- Pharmacy Utilization Measures
- Overturn Rates — Provider per 1000 per Year
- Select HEDIS rates for selected measures
- Other areas as identified
-

~~PROGRAM~~ROGRAM ~~EVALUATION~~VALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:
- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- ~~Drug Utilization Review~~ (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~~SATISFACTION ~~WITH THE~~WITH THE UM ~~PROCESS~~PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing, and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS)~~,~~; member/provider complaints and appeals that relate specifically to UM~~,~~; provider satisfaction surveys with specific questions about the UM process~~,~~; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on

the areas of concern which may include staff retraining and member/provider education.

2020
UTILIZATION MANAGEMENT
PROGRAM DESCRIPTION

2020 UTILIZATON MANAGEMENT PROGRAM
SIGNATURE PAGE

Utilization Management Committee Chair:

_____   _____

Himmet Dajee, M.D.   **Date**
Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

_____   _____

Paul Yost, M.D.   **Date**

Board of Directors Chair:

_____   _____

Paul Yost, M.D.   **Date**

TABLE OF CONTENTS

WE ARE CALOPTIMA

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

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

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

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

Our Values — CalOptima CARES

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

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

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.
- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

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

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

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

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

The five Strategic Priorities and Objectives are:
- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?
Our Unique Dual Role
CalOptima is unusual in that it is both a public agency and a community health plan.

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

WHAT WE OFFER

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

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, ACA expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS.

A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

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

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

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

Members with Special Health Care Needs

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

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

Medi-Cal Managed Long-Term Services and Supports

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

These integrated LTSS benefits include three programs:

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

OneCare

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

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and

Medicare Parts A and B. To be a member of OC, a person must live in Orange County, and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

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

OneCare Connect

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

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

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

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

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

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

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

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

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

Scope of Services

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

PROGRAM INITIATIVES

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information sharing platform was launched in November 2018. For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance.

As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitions to CalOptima in 2019. Under this program in Orange County, medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS. CalOptima planned to implement HHP in the following two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD), and July 1, 2020, for members with serious mental illness or Serious Emotional Disturbance (SMI).

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

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

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:
1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.

Homeless Health Initiative (HHI)

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

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:
- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provides additional respite care beyond the 90 days of recuperative care under the Whole Person Care program.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members.
- Homeless Clinical Access Program — The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.

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

Population Health Management (PHM)

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care

coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes Across Settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima has developed a comprehensive PHM Strategy, which includes actions to address the needs of our culturally diverse members across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards. CalOptima's PHM Strategy aims to ensure that care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

CalOptima's PHM Strategy is based on numerous efforts to assess the health and well-being of our members, such as the Member Health Needs Assessment. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.

The PHM strategy addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes.

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs providing health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct-Administration and/or CalOptima Community Network (CCN) and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN or one of 13 HNs, representing more than 8,500 practitioners.

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

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

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

CalOptima Contracted Health Networks

CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:
- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

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

Health Network/Delegate	Medi Cal	One Car	OneCare
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:
- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

MEMBERSHIP DEMOGRAPHICS

![CalOptima logo - Better. Together. A Public Agency]

Fast Facts: January 2020

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

Membership Data as of November 30, 2019

Total CalOptima Membership

755,539

Program	Members
Medi-Cal*	739,601
OneCare Connect	14,065
OneCare (HMO SNP)	1,498
Program of All-Inclusive Care for the Elderly (PACE)	375

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

Member Age (All Programs)

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

Languages Spoken (All Programs)

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

Medi-Cal Aid Categories

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

UTILIZATION MANAGEMENT PROGRAM

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes for review of health care services, treatment and supplies, including assignment of responsibility to appropriate individuals, to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, cost effective and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima members.

- Assist in the coordination of medically necessary medical and behavioral health care services in accordance with state and federal laws, regulations, contract requirements, NCQA Standards and evidence-based clinical criteria.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for activities regarding decisions based on medical necessity.
- Establish and maintain processes used to review medical and behavioral health care service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on Medical Necessity and/or benefit coverage.
- Identify and refer high-risk members to Case Management Programs, including Complex Case Management, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promote a high level of member, practitioner and stakeholder satisfaction.
- Protect the confidentiality of member protected health information and other personal information.
- Identify potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identify issues that contribute to over or underutilization or the inefficient or inappropriate use of health care services.
- Promote improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Educate practitioners and other providers, including delegated HNs, on CalOptima's UM Program, policies and procedures.
- Monitor utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.

UM Program Structure

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

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA) and NCQA at least annually. The UM Program is revised and improved, as appropriate. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network.

Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

The organization chart and the UM Program's committees reporting structure reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer; Deputy Chief Medical Officer; Medical Director(s) of UM; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima delegates UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM Program Description and CalOptima policies and procedures. Delegation is dependent upon the following factors:
- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:
- Frequent reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs UM activities by the Audit and Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA and CalOptima standards and program requirements.
- Annual approval of the delegate's UM program (or portions of the program that are delegated); as

well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation adjustments, or de-delegation.

Long-Term Services and Supports
CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:
- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B (NF-B)
  - Nursing Facility Level A (NF-A)
  - Subacute Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.

Home- and Community-Based Services:
- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT).
- 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.

Behavioral Health Services

Medi-Cal
CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Behavioral Health (BH) services include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger that meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific timeframe. CalOptima provides direct oversight, review, and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) (formerly Screening, Brief Intervention, and Referral to Treatment [SBIRT]) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

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

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

CalOptima offers AMSC services in the PCP setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Linkages with Community Resources
In addition, CalOptima provides linkages with community programs to members with special health care needs, or high risk or complex medical and developmental conditions. These linkages are established through special programs, such as the CalOptima Community Liaisons, PCCs, BH Integration (BHI), LTSS and specific program contracts and MOUs with other community agencies and programs, such as the OC HCA's CCS, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management department to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

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

The responsibility for the direction and management of the UM Program has been delegated to CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

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

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the QAC to review and make recommendations to the Board regarding accepting the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC also makes recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:
1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

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

The MAC membership is composed of representatives from the following constituencies:
- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children
- LTSS

- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

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

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

The OCC MAC membership is comprised of representatives from the following constituencies:
- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - OC HCA, Behavioral Health
    - OC IHSS Public Authority

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

Provider Advisory Committee
The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC is comprised of 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OC HCA, which maintains a standing seat. PAC meets at least quarterly and are open to the public. The 15 seats include:
- HN
- Hospitals
- Physicians (3 seats)
- Nurse

- Allied health services
- Community health centers
- OC HCA (1 standing seat)
- LTSS (LTC facilities and CBAS) (2 seats)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee
In 2018, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning WCM, 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 WCM. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:
- Family representatives: 7–9 seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18–21 who are a current recipient of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats
  - Community-based organizations; or
  - Consumer advocates

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

Role of CalOptima Officers for UM Program

CalOptima's CMO, Chairperson of the UMC, Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the 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), along with the Deputy Chief Medical Officer (DCMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

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

Executive Director, Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Case Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals and objectives. The ED of CO is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Medical Director, Utilization Management is appointed by the CMO and/or DCMO, and is responsible for the direction of the UM Program objectives, as well as evaluation of the UM Program. The medical director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. Provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The medical director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the bi-weekly UM Workgroup meetings and participates in the CalOptima Medical Directors Forum and QIC.

Medical Director, Behavioral Health is the designated behavioral healthcare practitioner in the QI and UM programs, and serves as a participating member of the UMC, QIC and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OC and OCC), MLTSS programs, Case Management and Transitions of Care programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The medical director works in collaboration with the other medical directors and the clinical staff within PHM, GARS, and Provider Relations. The medical director works closely with the nursing and non-clinical leadership of these departments.

Medical Director, Population Health Management, Health Education, Program for All Inclusive Care for the Elderly (PACE) is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of PHM, disease management and health education programs, while also providing clinical quality oversight of the PACE Center.

Director, Utilization Management
Director is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. This position will provide leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima's Utilization Management program for CalOptima Community Network, CalOptima Direct and the delegated health networks. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

Director, Behavioral Health Services provides operational oversight for BH benefits and services provided to members. The director is responsible for monitoring, analyzing, and reporting to senior staff on changes in the health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and BH care services. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executive staff, members, providers, HN management, legal counsel, state and federal officials, and representatives of other agencies.

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

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

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

Director(s), Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The directors ensure that CalOptima and its subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the directors lead the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the directors are responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. These positions interact with the Board of Directors, CalOptima executives, departmental management, HN management and Legal Counsel.

RESOURCES

UM Resources

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

Manager, Utilization Management (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in UM activities.

Supervisor, Utilization Management (CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima policies and procedures, and

regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education
- Current and unrestricted RN or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2–3 years supervisory/management experience in Utilization Management activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education
- Current and unrestricted RN license or LVN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education
- Current and unrestricted California Board LVN or CA RN license.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case

management functions performed at the HMOs, PHCs, and SRGs; and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- Current and unrestricted California Board LVN or RN license.
- Minimum of 3 years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They also authorize requested services according to departmental guidelines. All potential denial, and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education
- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

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

Experience & Education
- High school diploma or equivalent; a minimum of 2 years of college preferred.
- 2–3 years previous administrative experience preferred. Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.

Pharmacy Department Resources
The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the third-party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Experience & Education
- A current, valid, unrestricted California state Pharmacy License and Doctor of Pharmacy (Pharm.D) required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have

developed the knowledge and abilities listed.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T), Committee , interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education
- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years' experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima HNs and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy director in preparing drug monographs and reports for the P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education
- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years of experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a P&T.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are

trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education
- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, and perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. The director is responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.

Experience & Education
- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- 5–7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services (CBAS/LTC) is expected to develop and manage the LTSS department's work activities and personnel. The manager ensures that service standards are met, and operations are consistent with CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima's members who are eligible for and/or receiving LTSS. This position must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.

Experience & Education
- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5–7 years varied clinical experience required.
- 3–5 years supervisory/management experience in a managed care setting and/or nursing facility.

- Experience in government or public environment preferred.
- Experience in health with geriatrics and persons with disabilities.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and orientation and training of new employees to ensure contractual and regulatory requirements are met.

Experience &Education
- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for CalOptima members in LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, NCQA standards, and Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These positions are the subject matter experts and acts as liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience & Education
- A current and unrestricted RN license or LVN license in the State of California.
- Minimum of 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

Program Manager, LTSS is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. This position is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviewing the monthly files audit,

developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Experience & Education
- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred.
- Minimum of 3 years CBAS and program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office (approximately 5% of the time or more will involve traveling to CBAS centers and community events).

Behavioral Health Integration Resources

The following staff positions provide UM support for Behavioral Health Integration (BHI) operations:

Manager, Behavioral Health (Care Management) is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with CalOptima policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education
- Master's degree in Behavioral Health or other related degree is required.
- A current and unrestricted Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT) license in the State of California required, Licensed Psychologist is preferred.
- 4 years of supervisor or manager level experience required.
- 1 year experience in behavioral health audits (including CMS, DHCS, DMHC and NCQA).
- 1-year experience in developing policies and procedures to meet federal and state regulatory requirements.
- 1-year experience in developing sound and responsible business plans and financial models preferred.

Program Manager, Sr. (BH) is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral Health Services (Integration), Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities.

Experience & Education

- Bachelor's degree in a behavioral health related field required; Master's degree in Health Administration, Social Work, Marriage and Family Therapy, Public Health, or other related degree preferred.
- 4 years of experience working in a managed care environment, with specific experience in BH UM.
- 4 years of supervisor or manager level experience required.
- Experience in a government or public environment strongly preferred.
- 2 years of experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program required.
- 2 years of experience and aptitude for working in a highly matrixed, mission-driven organization required.

Supervisor, Behavioral Health, (BHT) is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The Supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best practice" guidelines. The Supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.

Experience & Education
- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 3 or more years of supervisor level experience in clinical management of ABA services is required.
- 3 or more years of experience providing ABA therapy to children diagnosed with autism spectrum disorder (ASD) is required.

Medical Case Managers (BH) are responsible for clinical review and recommendations related to Interdisciplinary Care Team (ICT) meetings, inpatient and outpatient psychiatric authorization requests from BH providers and completing inpatient CCR and transitional care for OC and OCC members. They are responsible for adhering to CalOptima's prior authorization approval process which includes reviewing authorization requests for medical necessity, consulting with the manager and Medical Director as needed. They also review prior authorization requests for outpatient mental health services.

Experience & Education
- Current and unrestricted RN license to practice in the State of California
- Minimum of 3 years current BH clinical experience or an equivalent combination of education and experience required.
- Active Certified Case Manager (CCM) certification preferred.
- Experience in a prior authorization and/or managed care environment preferred.
- Experience with inpatient concurrent review strongly preferred.

Medical Case Manager (BH) is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. Utilizes medical criteria, policies, and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers

Experience & Education

- High school diploma required, Associates or Bachelor's degree in related field preferred
- Current and unrestricted LVN license to practice in the State of California required
- 3 years of clinical experience required
- Inpatient behavioral health experience preferred
- Active CCM certification preferred

Care Manager is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.

Experience & Education
- Master's degree in Behavioral Health or another related field is required.
- Board Certified Behavioral Analyst (BCBA) or Board-Certified Behavioral Analyst-Doctoral (BCBA-D) is required.
- 4 or more years providing ABA therapy to children diagnosed with ASD is required.
- Experience in clinical, medical utilization review, and/or quality assurance is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.

Experience & Education
- High school diploma or equivalent is required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's license and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

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

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:
- CalOptima New Employee Orientation.
- HIPAA and Privacy/Corporate Compliance.

- Use of technical equipment (phones, computers, printers, facsimile machines, etc.).
- UM Program, policies/procedures, etc.
- MIS data entry.
- Application of Review Criteria/Guidelines.
- Appeals Process.
- Seniors and Persons with Disabilities Awareness Training.
- OC and OCC Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health professionals provide day-to-day supervision of assigned UM staff, as well as oversight of the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical management staff is required to sign an Affirmative Statement regarding this prohibition annually.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2020 Committee Organization Structure — Diagram
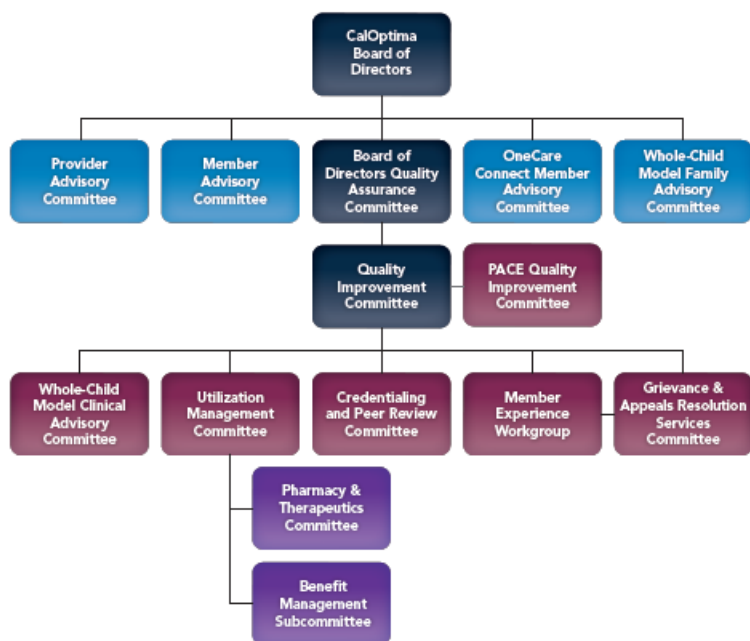
UMC

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

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC which reports up to QIC and ultimately to QAC and the Board of Directors.

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

- 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 under/over utilization monitoring in accordance with UM Policy and Procedure GG.1532 Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:
  Direct Subcommittee Reports:
  - Benefit Management Subcommittee (BMSC)
  - P&T

  Departments Reporting Relevant Information on UM Issues:
  - Delegation Oversight
  - Behavioral Health
  - Grievance and Appeals
  - UM Workgroup
  - LTSS
- Reports to the QIC on a quarterly basis; communicates significant findings and makes recommendations related to UM issues.

UMC Membership
Voting Members:
- CMO
- Medical Director UM
- Medical Director Behavioral Health
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

* Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists, and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:
- Director, UM
- Medical Director, Whole Child Model

- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division (MMCD), All Plan Letters (APLs), and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:
- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership
- Medical Director, Utilization Management — Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets at least six times per year, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program
The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.
- The UM program is evaluated, revised and prepared for approval by the UM Director in conjunction with the Executive Director of Clinical Services, Chief Medical Officer, Deputy Chief Medical Director and Utilization Management Medical Director prior to submission for committee review and approval.
- Utilization data is collected, aggregated and analyzed including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or under utilization.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, Managed LTSS Programs, P&T, QI, Credentialing, Compliance, and Audit and Oversight are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:
- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Conflict of Interest
CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Confidentiality
CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members

of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

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

UM PROCESS

The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization 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, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit and Oversight department via its delegation oversight team for compliance.

REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

Medical necessity review requires consideration of the members' circumstances, relative to appropriate clinical criteria and CalOptima policies, applying current evidence-based guidelines, and consideration of available services within the local delivery system. These decisions are consistent with current evidence-based clinical practice guidelines.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with CMS and the State of California for Medi-Cal, OC and OCC. Medically necessary means:

- 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 member under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d(r) and California Welfare and Institutions Code sections 14132(v).

- For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

The CalOptima UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost-efficient manner, without compromising quality. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:
- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization inpatient review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for health network members

The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:
- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
  o Age
  o Co-morbidities
  o Complications
  o Progress of treatment
  o Psychological situation
  o Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or

guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure GG.1508, Authorization and Processing of Referrals.

- Reasons for decisions are clearly documented in the medical management system, including criteria used to make the determination.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer) or a copy of the specific criteria utilized.

The information that may be used to make medical necessity determinations includes, but is not limited to:
- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima

program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Link system allows for non-urgent on-line authorizations to be submitted by providers and processed electronically. Some referrals are auto adjudicated through referral intelligence rules (RIR). Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of- network practitioners

Second Opinions
A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in-network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "Standing Referral" policy and procedure, Standing Referral: GG.1112, includes guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a

number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and CalOptima's Director, Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima website.

The P&T is responsible for development of the CalOptima Approved Drug List (Formulary), which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers. If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate, and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's PBM for review. All potential authorization denials are reviewed by a pharmacist at CalOptima, as per DHCS requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for

members receiving multiple medication fills per month are reviewed by a clinical pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

Pharmacy Determinations

Medi-Cal
CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the P&T. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima pharmacist or Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima pharmacist or Medical Director. CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.

OC/OCC
CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Formulary
The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the P&T. Final approval from the P&T must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.

Pharmacy Benefit Manager
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 and Oversight department's policies and procedures.

BEHAVIORAL HEALTH DETERMINATIONS

Medi-Cal
CalOptima's BHI department performs prior authorization review for BHT services and psychological

testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, APL, and CalOptima policy (approved by DHCS).

OC/OCC

CalOptima has previously delegated Magellan Health Inc. to directly manage the behavioral health utilization management functions for OneCare/OneCare Connect. Effective January 1, 2020, CalOptima's BHI department will perform prior authorization review functions for OC/OCC covered behavioral health services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, and psychological testing. Prior authorization requests are reviewed by BH Medical Case Managers. Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL), and CalOptima policies.

The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a Licensed CalOptima Psychologist or Medical Director. CalOptima's written notification of BH modifications and denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
  A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss BH UM denial decisions.

UM CRITERIA

CalOptima conducts Utilization Review using UM criteria that are nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

Medi-Cal

1. Federal and state law mandates (i.e. CMS, DHCS)
2. Medi-Cal Manual of Criteria and Medi-Cal Benefits Guidelines
3. EPSDT
4. Nationally recognized evidence-based criteria such as Milliman Care Guidelines (MCG), U.S. Preventative Services Task Force Recommendations and National Comprehensive Cancer Guidelines, etc.
5. Transplant Centers of Excellence guidelines
6. Preventive health and/or society guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology [ACOG] Guidelines, American Medical Association (AMA) and National Guidelines Clearinghouse)
7. CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines

Whole Child Model

In addition to the Medi-Cal hierarchy above:
1. CCS Numbered Letters (N.L.s) and county CCS Program Information Notices for decisions related to CCS and Whole Child Model.

Medicare

For OC and OCC:
1. Federal and state law mandates (i.e. CMD, DHCS)
2. CMS Guidelines Local and National Coverage Determinations (LCD, NCD)
3. Medicare Part D: CMS-approved Compendia (for medications)
4. Medi-Cal Manual of Criteria and Medi-Cal Benefits Guidelines
5. Nationally recognized evidence-based criteria such as MCG, UpToDate, U.S. Preventative Services Task Force Recommendations, and National Comprehensive Cancer Guidelines, etc.
6. Transplant Centers of Excellence guidelines
7. Preventive health and/or society guidelines (e.g., U.S. Preventive Services Task Force, ACOG Guidelines, AMA, National Guidelines Clearinghouse)
8. CalOptima Policy & Procedures and/or Clinical Benefits & Guidelines

Delegated HNs must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case- specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Authorization Types

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse Reviewer**	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Inpatient hospital services	MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	MCG / Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals		X	
Transplants	DHCS Guidelines/ MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination.

** If Medical Necessity criteria is not met, the request is referred to a Medical Director/Physician Reviewer for further review and determination.

Long-Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		X	X
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		X	X
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		X	X
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51003 and 51303		X	X
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long- Term Care Services / Title 22, CCR, Sections 51343 and 51164	X DDS or DMH Certified	X	X
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	X	X	X

* If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	X		X
Behavioral Health Treatment (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	X	X	X

* If Medical Necessity is not met, the request is referred to the Medical Physician Reviewer/Licensed Psychologist for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may

consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

New Technology Review
The P&T and BMSC shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for members, in accordance with CalOptima Policy GG.1534 Evaluation of New Technology and Uses.

Practitioner and Member Access to Criteria
At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptima Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as, UM timeliness of decisions. In addition, Provider Relations also provides any related policies with regard to UM timeliness of decisions. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability
At least annually, the CMO and Executive Director, Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director, Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the committee.

Provider and Member Communication
Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at **800-735-2929**. The phone numbers for these are included in the Member Handbook, on the CalOptima website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (BH and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling the direct dial number for the Medical Director at the bottom of the provider denial notification. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner. Whenever a peer-to-peer request is made, documentation is added to the denied referral within Guiding Care, our UM system.

UM Staff Access to Clinical Expertise

The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated HNs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective and concurrent telephonic review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information

CalOptima's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g. discharge planning, case management, disease management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member

CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to

minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

Medi-Cal (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
Routine (Non-Urgent) Pre-Service: Prospective or concurrent service requests where no extension is requested or needed	Approve, modify or deny within 5 working days of receipt of " all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 14 calendar days following receipt of request. "All information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Within 24 hours of the decision	**Practitioner:** Within 2 working days of making the decision **Member:** Dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service.
Routine (Non-Urgent) Pre-Service **Extension Needed** (AKA: Deferral) • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed	Due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The member or the member's provider may request for an extension, or the plan can provide justification upon request by the state for the need for additional information and how it is in the member's interest. The delay notice shall include the additional information needed to render the decision, the type of expert needed to review, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.	**Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request	**Practitioner:** Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. **Member:** Dated and postmarked within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

| Type of Request | Decision | Notification Timeframe | |
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	Additional Requested Information is Received: A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional information incomplete or not received:** If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.		
Expedited Authorization Requests (Pre-Service): No extension requested or needed. All necessary information received at time of initial request. Requests where a provider indicates, or the plan determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, modify or deny within 72 hours from receipt of request	**Practitioner:** Within 24 hours of making the decision, not to exceed 72 hours from receipt of the request.	**Practitioner:** Within 72 hours of the request. **Member:** Postmarked and mailed within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) Extension needed: Extension is allowed *only* if member or provider requests the extension or the plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member.	The plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the plan asks the member, the member's representative, or provider for the specific information necessary to make the decision.	**Practitioner and Member:** Within 24 hours of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination.

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May be Oral and/or Electronic)**	**Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member**

	▪ The plan gives the member or member's authorized representative at least 48 hours to provide the information.
	▪ The extension period, within which a decision must be made by the plan, begins:
	  o On the date when the plan receives the member's response (even if not all of the information is provided), *or*
	  o At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.
			Member:
			Within 2 business days of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination (written notification)
			
			Note: CalOptima shall make reasonable efforts to give the member and prescribing provider oral notice of the delay.

	Expedited (Urgent) Pre-Service request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met:
	▪ A request for services where application of the time frame for making routine or non-life-threatening care determinations:
	  o Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
	  o In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
		Practitioner:
		Within 24 hours of making the decision
			Practitioner:
			Within 2 working days of <u>making</u> the decision
			
			Member:
			Within 2 working days of making the decision

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	o The member or the member's provider may request for an extension, or the health plan/provider group can provide justification upon request by the state for the need for additional information and how it is in the member's interest. o 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. o Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the health plan's decision, and a care plan has been agreed	Within 24 hours of receipt of the request **NOTE:** The plan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the plan previously; the plan documents that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to. The plan has up to 72 hours to make a	**Practitioner and Member:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision **Member:** Within 24 hours of making the decision For terminations, suspensions, or reductions of previously authorized services, the plan must notify beneficiaries at least 10 days before the date of the action with the exception of circumstances

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
upon by the treating provider that is appropriate for the medical needs of that member	decision (NCQA UM 5). o A response to defer is required within 24 hours for all services that require prior authorization. o A decision to approve, modify, or deny is required within 72 hours, or as soon as a member's health condition requires, after the receipt of the request. o If the plan is unable to request for an extension of an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		permitted under Title 42, CFR, Sections 431.213 and 431.214.
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
Post-Service: Extension needed Additional clinical information required	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request.	**Member & Practitioner**: None specified	**Practitioner / Member:** For ALL Decision Types: Written notice within 30 calendar days from receipt of the information necessary to make the determination.
	Additional Information Received: If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Member & Practitioner**: None specified	
	Additional Clinical Information Incomplete or Not Received: Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified	
Hospice - Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Within 24 hours of making the decision **Member:** None Specified	**Practitioner / Member:** Written notice within 2 working days or making the decision.

Medicare (Excludes Pharmacy Requests)

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) If no extension requested or needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) If extension requested or needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	***Extension Notice:*** Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: The reasons for the delay The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification After an Extension:*** Must occur no later than expiration of extension.

Expedited Initial Organization Determination If expedited criteria are not met	Promptly decide whether to expedite — determine if:
	1. Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or
	2. If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision.
	  o If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies:
	    ▪ Automatically transfer the request to the standard timeframe.
	    ▪ The 14-day period begins with the day the request was
		If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice.
		
		The written notice must include:
		1. Explain that the health plan will automatically transfer and process the request using the 14-day timeframe for standard determinations.
		2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination.
		3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	received for an expedited determination.	4. Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination If no extension requested or needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends and holidays).	Within 72 hours after receipt of request. ▪ **Approvals** o Oral or written notice must be given to member and provider within 72 hours of receipt of request. o Document date and time oral notice is given. o If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** o When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request.
Expedited Initial Organization Determination If extension requested or needed	May extend up to 14 calendar days. Note: Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers. ▪ When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request).	*Extension Notice:* Give notice in writing, within 72 hours of receipt of request. The extension notice must include: ▪ The reasons for the delay ▪ The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ▪ Note: The health plan must respond to an expedited grievance within 24 hours of receipt. *Decision Notification* After an Extension: ▪ Approvals o Oral or written notice must be given to member and provider no later than upon expiration of extension. o Document date and time oral notice is given. If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. ▪ Denials o When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. o Document date and time of oral notice. o If only written notice is given, it must be received by member and provider no later

Type of Request	Decision	Notification Timeframe Member and Practitioner
	▪ Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	than upon expiration of extension.

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal Pharmaceutical — Decision Making	OC and OCC Pharmaceutical — Decision Making
• Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals	• Processed by CalOptima Pharmacy Management department • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals

Medi-Cal Pharmacy Timeframes for Determinations	OC and OC C Pharmacy Timeframes for Determinations (Part D):
Standard (Non-urgent) Preservice: Within 24 hours a decision to approve, modify, deny or defer is required. **Standard (Non-urgent) Preservice, Extension Needed:** Within 5 working days of receiving needed information, but no longer than 14 calendar days **Expedited (Urgent) Preservice/Concurrent:** Within 24 hours a decision to approve, modify, deny or defer is required. **Expedited (Urgent) Preservice/Concurrent, Extension Needed:** Within 72 hours of the initial request **Post-Service/Retrospective:** Within 30 days of receipt	• Routine: 72 hours • Urgent: 24 hours • Retrospective: 14 days

Medi-Cal Pharmacy Timeframes for Notification	OC and OCC Pharmacy Timeframes for Notification (Part D)
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. **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. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Services

A hospital must submit a Prior Authorization Request for Post-Stabilization Services when a member who has received emergency services for an emergency medical condition is determined to have reached medical stability, but requires additional, medically necessary inpatient covered services that are related to the emergency medical condition, and provided to maintain, improve or resolve the member's stabilized medical condition.

CalOptima or a HN shall approve or deny within 30 minutes after receiving a prior authorization request for post- stabilization services and all information reasonably necessary and requested to render a decision from a hospital for Medi-Cal members, , and within 60 minutes after receiving such request and information from a hospital for OC or OCC members. If CalOptima or the HN does not respond within the prescribed time frame, medically necessary post-stabilization services are considered approved.

PRIOR AUTHORIZATION SERVICES

UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director, UM or designee, reviews the request for retrospective authorization. Retrospective Authorization shall only be permitted in accordance with CalOptima Policy and Procedure GG.1500 Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Concurrent Review Process

In addition to authorization for post-stabilization services that often result in an inpatient admission, facilities are also required to notify CalOptima of all inpatient admissions within 1 business day following the admission. The admission/concurrent review process assesses the clinical status of the member, verifies the need for continued hospitalization, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed
- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension of the treatment or service

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre- service and post-service).

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.
Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in GG.1508 Authorization and Processing of Referrals. The written notification is written in lay language that is easily understandable at the 6th grade level and includes the member specific reason/rationale for the determination, specific

criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

GRIEVANCE AND APPEAL PROCESS

CalOptima has a comprehensive review system to address matters when Medi-Cal, OC or OC C members wish to exercise their right to review a UM decision to deny, delay, or modify a request for services, or terminate a previously-approved service. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.
The grievance process is in accordance with CalOptima Policy HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process. This process includes:
- Collection of information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima GARS. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination. The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM or CM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

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

Expedited Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Hearing

CalOptima Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC and OCC members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima is notified when a request is made by a member or member representative. CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima of the outcome of their review. If the decision is overturned, CalOptima complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:
1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

LONG-TERM SERVICES AND SUPPORTS

LTC
The LTC case management program includes authorizations for the following facilities:
- NF-A and NF-B, sub-acute care

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, congregate living health facilities and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. There are two types of NFs: Onsite NFs where nurses make monthly or bi-monthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either an on-site visit or FAX-IN process is scheduled to assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system (for onsite only). Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS or to a CBAS facility. Referrals to case management can also be made upon discharge when member needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

CBAS
An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include: health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational, and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center.

MSSP
CalOptima has responsibility for the payment of the MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs; case management; money management and counseling; respite; housing assistance; assistive devices; legal services; transportation; nutrition services; home health care; meals; personal care assistance with hygiene; personal safety; and activities of daily living.

Transitions of Care
Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members

discharged from Fountain Valley Regional Hospital (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:
- **Knowledge of Red Flags**: Member is knowledgeable about indications that their condition is worsening and how to respond.
- **Medication Self-Management**: Member is knowledgeable about medications and has a medication management system.
- **Patient-Centered Health Record (PHR)**: Member understands and uses a PHR to facilitate communication with their health care team and ensure continuity of care across providers and settings.
- **Physician Follow-Up**: Member schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Case Management Process
The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable. For further details of the structure, process, staffing, and overall program management please refer to the 2019 Case Management Program document.

Transplant Program
The CalOptima Transplant Program is coordinated by the Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program.

Coordination of Care
Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit

limitation. Because Medi-Cal is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider in certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes into CalOptima or a member terminates from CalOptima to a new health plan.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM and reported to UMC. Measures are monitored and reviewed for over and underutilization, and/or changes in trends. Actions are determined based on trends identified and evaluated for effectiveness.

The following are measures tracked and monitored for over/under utilization trends:
- ER admissions
- Bed Days
- Admits per 1000
- Average Length of Stay
- Readmission Rates
- Denial Rates
- Pharmacy Utilization Measures
- Overturn Rates — Provider per 1000 per Year
- Select HEDIS rates for selected measures
- Other areas as identified

PROGRAM EVALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director, UM evaluate the impact of the UM Program by using:
- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- (DUR profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC and QAC for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, Fair Hearing, and Independent Review

processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima QI department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

Impact of COVID-19 on Quality Activities and Population Health Management

Quality Assurance Committee
May 20, 2020

Kelly Rex-Kimmet, Director, Quality Analytics
Esther Okajima, Director, Quality Improvement
Pshyra Jones, Director, Population Health Management
Edwin Poon, Director, Behavioral Health Integration

Quality Reporting Impact: CMS Guidance

- Due to the impact of COVID-19 on provider offices, Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) have issued guidance related to quality reporting requirements for measurement year (MY) 2019.

  ➢ CMS has suspended the requirement for Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results to be reported to CMS for MY 2019 performance.

  ➢ This impacts our OneCare program.

  ➢ CMS will use prior year (2018) HEDIS and CAHPS scores to calculate STARS scores and payments.

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Quality Reporting Impact: CMS Guidance (cont.)

➢ Health Outcomes Survey has been delayed by CMS. Expected to field in late summer.

➢ Awaiting guidance for Medicare-Medicaid (MMP) plans (One Care Connect) regarding submission of MY 2019 results.

➢ CAHPS survey for MMP plans was not suspended.

Quality Reporting Impact: DHCS and Pay For Value (P4V)

- CalOptima will continue to compile MY 2019 HEDIS results for all programs and will continue our HEDIS audit process.

  - ➤ This ensures data for quality improvement and evaluation of quality initiatives.

  - ➤ This also allows our Medicaid HEDIS and CAHPS results to be submitted as part of our National Committee for Quality Assurance (NCQA) accreditation process.

  - ➤ Final HEDIS/CAHPS results for MY 2019 for all programs will be shared at September QAC.

Quality Reporting Impact: DHCS and P4V (cont.)

- ➢ We await guidance from DHCS regarding whether the new managed care accountability set (MCAS) measures will still be held to minimum performance levels and possible financial sanctions.

- ➢ We do not expect COVID-19 to have any adverse impact on 2019 P4V scoring or payments.

- ➢ NCQA is suspending calculation of health plan ratings based on 2019 performance due to COVID-19.

- ➢ CalOptima is expected to retain our top-level plan rating of 4.0 for an additional year.

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COVID-19 Impact

Member Experience

- Members cancelling appointments because they are afraid to go out
- Members requesting locations of testing sites
- Members asking about coverage for COVID-19
- Members complaining their providers do not have testing available
- Members complaining their providers won't see them due to outbreak of COVID-19
- Members inquiring about providers who do telehealth visits due to anxiety of going in person
- Members receive delay in care due to adjusted hours, rescheduled or cancelled appointments, e.g., not able to obtain durable medical equipment (DME), medications, not able to access provider, etc.

Provider Experience

- Providers changing hours, consolidating services and sites
- Providers cancelling elective surgeries and procedures
- Providers changing to phone consultations/telehealth
- Providers unclear about testing sites and current testing strategy
- Providers new to Medi-Cal can emergency enroll through DHCS to see members at Medi-Cal rates
- Provider Facility Site Reviews temporarily on hold due to COVID-19, impacting credentialing and tri-annual FSR

Member Experience — GARS Grievances

GARS Grievances

- Billing 3%
- COVID Testing 23%
- Delay in Care 60%
- Transportation 4%
- UM Related 4%
- Other 6%
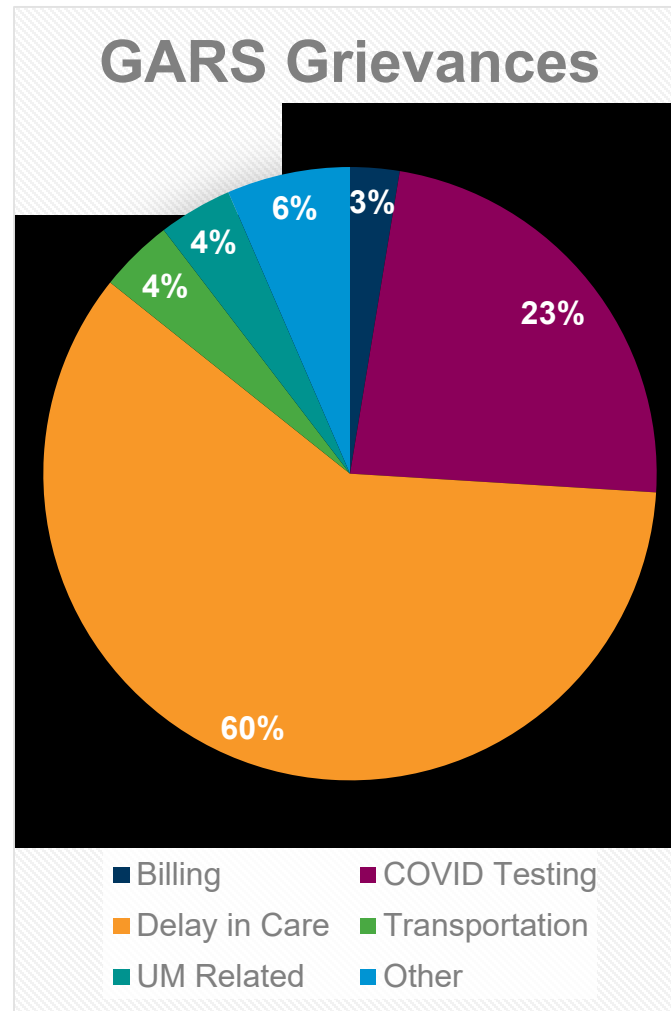
Total Grievances as of May 1, 2020: 77

Member Experience — GARS Top Grievances by Sub-Category

Delay in Care

Pie chart legend:
- Appointment Delay
- Canceled
- DME Delay
- Rx Delay
- Rescheduled
- No access, not seeing patients
- No access, unable to reach provider
- Virtual/Telephone-Member Dissastisfied
- Undefined

Pie chart values: 18%, 15%, 9%, 11%, 4%, 28%, 9%, 4%, 2%
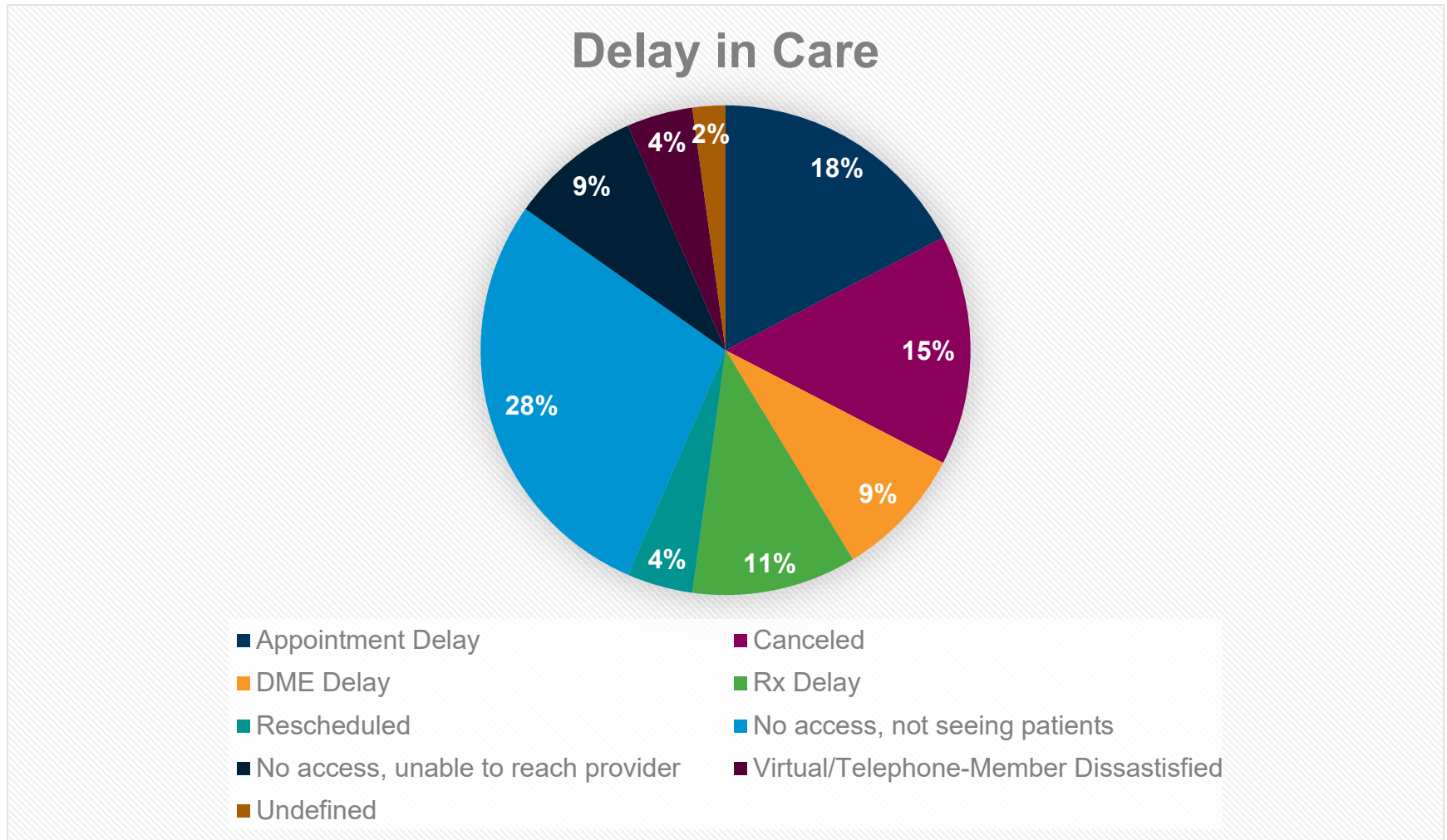
Grievances sub-category as of May 1, 2020: 46

Member Experience — GARS Top Grievances by Sub-Category (cont.)

COVID Testing

- 6% Did not get test results
- 39% Office would not refer or test member
- 5% Unable to schedule or reach provider for test
- 6% PCP advised member to seek testing
- 28% ER/UC and denied testing
- 11% Office did not know where to refer, run-around
- Antibodies

Grievances sub-category as of May 1, 2020: 18

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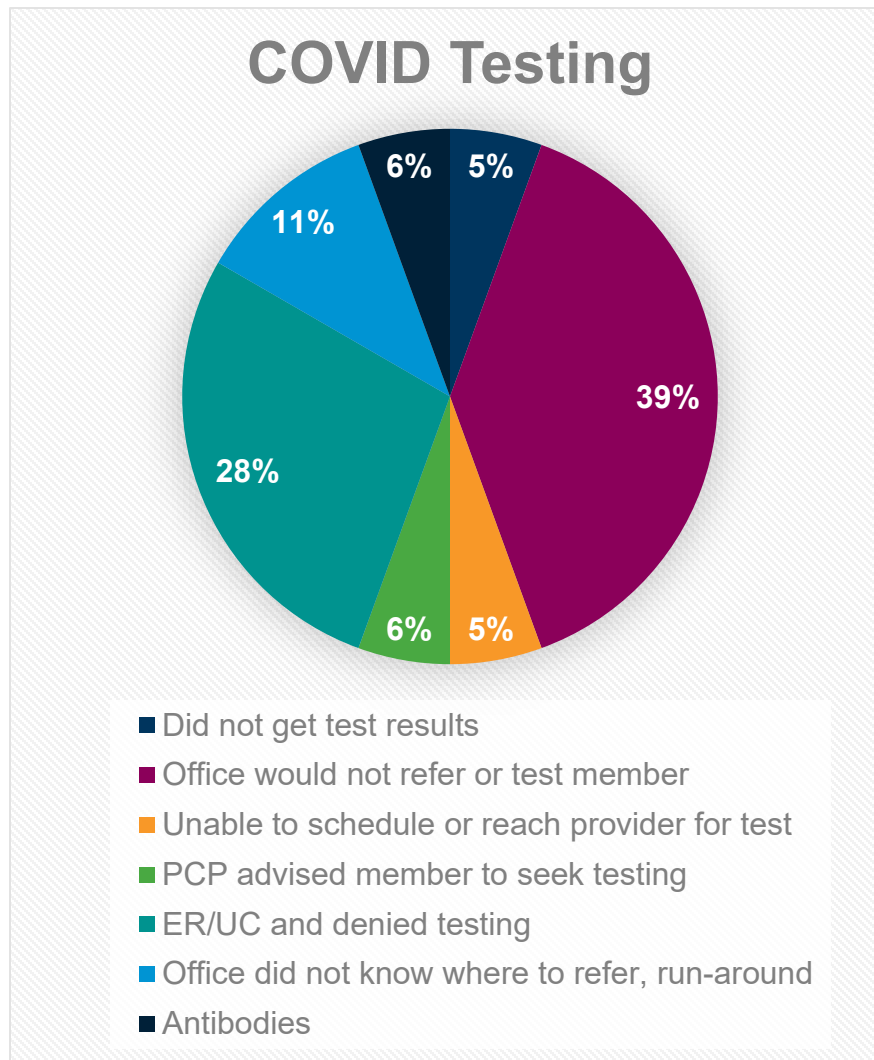
Member Experience: Customer Service Inquiries

Customer Service Inquiries

Horizontal bar chart showing Customer Service Inquiries by category:

Category	Customer Service Inquiries
Rx Benefits (general)	~35
PA-Member Prior Auth Inquiry	~35
Provider/HN Eligbility	~68
COVID: Misc.	~26
COVID: Member cancel doctor appointment	~4
COVID: Depression, anxiety (BH)	~18
COVID: Financial assistance and food servces	~7
COVID: Members asking about transportation benefits	~6
COVID: Rx 90 day benefits for COVID-19	~13
COVID: Telehealth	~31
COVID: Testing	~106

■ Customer Service Inquiries

Total C/S Complaints as of April 24, 2020: 349

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Provider Relations — Notification/Inquiry Log

Provider Notification/Inquiry Log

Pie chart: COVID-19 Questions/Inquiry 6%, COVID-19 Testing 12%, PPE 5%, CBAS and modified office hours 29%, Prior Authorization 5%, Transportation 2%, Telehealth 14%, Managing and requesting data 2%, Audit and reporting 6%, Communication to members 7%, Other 12%
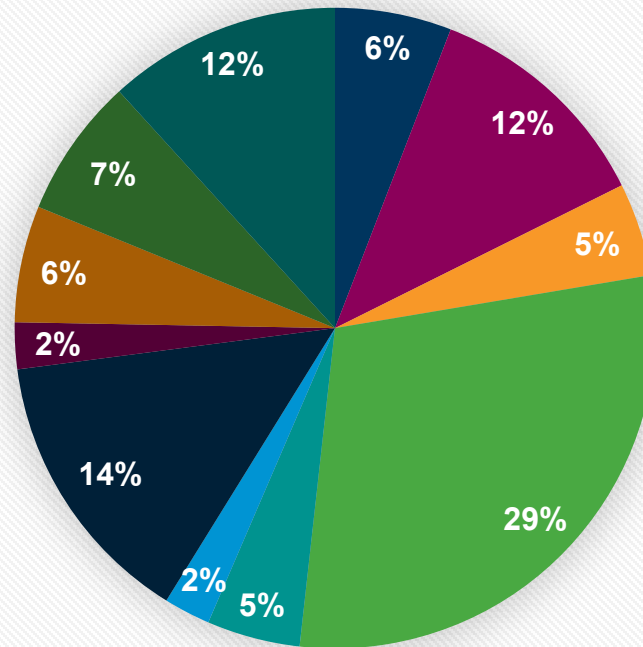
Legend:
- COVID-19 Questions/Inquiry
- COVID-19 Testing
- PPE
- CBAS and modified office hours
- Prior Authorization
- Transportation
- Telehealth
- Managing and requesting data
- Audit and reporting
- Communication to members
- Other

Total Provider Relations entries as of April 24, 2020: 85

Back to Agenda

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NCQA Accreditation Impact

- Extending the grace period two months to allow 16 months for annual requirements such as analysis, member communications and delegation oversight

- Extending practitioner and provider recredentialing cycle by two months to 38 months

- File review preparations in progress, lookback period begins May 2020

- Potentially removing files from May–September from credentialing, UM denial/appeal and complex case management files from the universe, as documented in disaster management plans

- No impact to submission, scheduled May 21, 2021

Population Health Management

- Outreach to emerging risk populations
  - Bright Steps Maternity Management Program
    - Including "You are Not Alone" First 5 OC Coronavirus pamphlet in CalOptima Bright Steps weekly mailings
    - Informing Bright Steps participants about changes to hospital labor and delivery protocols
    - Screen everyone who comes and goes, allow one additional person plus delivering mom in delivery room, and require wearing a mask, etc.
  - Chronic Conditions
    - Modified scripts for members with asthma, diabetes and COPD to educate COVID-19 prevention strategies and offering CalOptima assistance with medication refills, medical equipment or community resources

- General education
  - COVID-19 outreach and prevention awareness interactive voice response (IVR) campaign
  - COVID-19 educational videos on CalOptima website

Population Health Management (cont.)

- COVID-19 Community Awareness Campaign
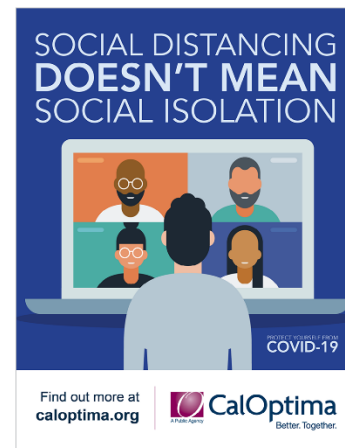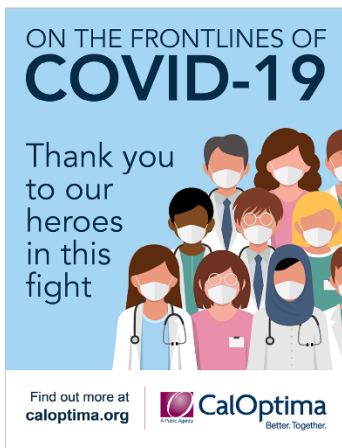
Population Health Management (cont.)

- Public service announcements to support CalOptima vulnerable populations impacted by COVID-19
  - ➢ Taking Care of Your Emotional Health
  - ➢ Maternal Mental Health
  - ➢ Continuing Prenatal Care
  - ➢ Healthy Nutrition and Activity
  - ➢ Chronic condition management and support with medications
- Link to video spots…

Mitigating Health Impact of Secondary Stress Due to COVID19 Emergency

Quality Assurance Committee

May 20, 2020

Edwin Poon, Ph.D.

Director, Behavioral Health Services (Integration)

DHCS APL 20-008

- Support continuity and integration of medical and behavioral health (BH) services via telehealth.

- Ensure strong care coordination and service linkage.

- Educate providers on disaster-responsive, trauma informed care.

- Ensure providers learn the signs of and assess for stress-related morbidity and create responsive treatment plans.

Member-Focused Activities

- Expansion of telehealth for BH

- Identified BH providers specialize in trauma-informed care and anxiety disorders, e.g. post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD)

- Licensed BH clinicians available in real time to assist members in mental health crisis

- Offer members seeking mental health services appointment assistance

- Train all BH staff on Adverse Childhood Experiences (ACEs) and trauma-informed care

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Provider-Focused Activities

- Identify online resources/supports for providers and health networks (HN).

- Alert providers and HNs about trainings on ACEs, trauma-informed care, emotional resilience and other topics on stress related to COVID-19.

- Educate HNs, providers and internal staff on how to support members with mental health concerns due to COVID-19 health emergency.

Community-Focused Activities

- Collaboration with county behavioral health services and Be Well OC on sharing mental health resources

  - https://coronavirus.egovoc.com/health-care-providers-first-responders

  - https://mental-wellness.bewelloc.org/

  - https://www.caloptima.org/en/Features/COVID-19/CommunityCommunication.aspx

- Educate community-based organizations on how to support members with mental health concerns due to COVID-19 health emergency.

Questions?

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

Members Experiencing Homelessness Update

Board of Directors' Quality Assurance Committee

May 20, 2020

Marie J. Jeannis, RN, MSN

Director, Enterprise Analytics (Interim)

Content Overview

- Goals
- CalOptima Homeless Population Clinical Report Card
- Homeless Enrollment Trends
- Homeless Utilization Trends
  - Primary Care Provider (PCP) Visit Trends
  - Specialist Visit Trends
  - Telehealth Service Trends
  - Inpatient (IP) Trends
  - Emergency Department (ED) Trends
- Disparities: Medical and Behavioral Health (BH) Diagnoses
- Coroner's Report Monthly Cases
- Summary

Goals

- Homeless population clinical analysis goals
  - ➤ Define and understand the population
  - ➤ Improve the quality and scope of data collection
  - ➤ Improve data integrity
  - ➤ Increase data sources
  - ➤ Assess current interventions
  - ➤ Identify opportunities for change or improvements

CalOptima Homeless Report Card

- CalOptima's Homeless Population Clinical Report Card is reported quarterly and monitors key performance measures for this vulnerable population

- Homeless Population Clinical Report Card trends:
  - ➢ Enrollment
  - ➢ Utilization metrics
  - ➢ Metrics for homeless initiatives
    - ▪ Clinical Field Team (CFT) Visits
    - ▪ Mobile Clinic Visits

CalOptima Homeless Population Clinical Report Card

Enrollment Per Year
From: 2015 To: 2020-02

	2015	2016	2017	2018	2019	2020 YTD
Total Homeless Members	6,843	7,670	9,142	10,910	11,585	11,351
Enrolled in Whole Person Care			3,612	5,078	5,244	4,756
Enrolled in Health Homes Progam						258

Telehealth Services
Last 12 months by Quarters

	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2
Telehealth Visit Ct	0	0	2	95	73

Clinical Field Team (CFT) Visits
From: 2019-04 To: 2020-03 (3/31/20)

	2019 Q2	2019 Q3	2019 Q4	2020 Q1	Total
# Calls Dispatched	96	183	226	167	672
% Treated	100%	100%	100%	100%	100%
% CalOptima Members (Treated)	92%	83%	88%	92%	88%
% Recuperative Care Referrals (Treated)	8%	19%	20%	20%	17%

CFT Mobile Clinic Visits
From: 2019-04 To: 2019-12

Place Of Service	Q2 2019	Q3 2019	Q4 2019	Total
Homeless Shelter	1		6	7
Mobile Unit	6	7	2	15
Temporary Housing		5	5	10
Other Unlisted Facility	0	12	11	24
Grand Total	7	25	25	56

Utilization Metrics
From: 2015-01 To: 2019-12

PCP and Specialist Visit Rates

	2015	2016	2017	2018	2019
Number of PCP Visits	10,073	9,990	13,287	16,111	16,617
PCP Visits Per Member	1.5	1.3	1.5	1.5	1.4
% With PCP Visit	30%	28%	30%	33%	36%
Number of Specialist Visits	12,706	15,872	25,540	34,432	38,382
Spec Visits Per Member	1.9	2.1	2.8	3.2	3.3

Inpatient Metrics

	2015	2016	2017	2018	2019
Admits	1,736	2,207	3,553	4,656	5,173
Admits PTMPY	254	288	389	427	446
Bed Days	8,547	9,362	17,111	22,965	28,191
Bed Days PTMPY	1,249	1,221	1,871	2,105	2,433
% Readmit	20%	23%	26%	28%	31%

Emergency Department Rates

	2015	2016	2017	2018	2019
ED Visits	10,785	12,761	18,411	23,041	26,602
ED Visits PTMPY	1,576	1,664	2,014	2,112	2,297

Workbook: Quarterly QIC Reporting Tableau Workbook_Final   Report Date: 5/12/2020

Source: CalOptima data

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Homeless Enrollment Trends

- Number of homeless Medi-Cal members has increased significantly, especially after the start of the Whole Person Care (WPC) Program
  - WPC enrollment began in 2017
  - Heath Homes program began in 2020

Enrollment Per Year
From: 2015 To: 2020-02

	2015	2016	2017	2018	2019	2020 YTD
Total Homeless Members	6,843	7,670	9,142	10,910	11,585	11,351
Enrolled in Whole Person Care			3,612	5,078	5,244	4,756
Enrolled in Health Homes Progam						258

Source: CalOptima data

Primary Care Provider Visit Trends

- Percent of homeless members with at least one annual PCP visit has been increasing

Percent of PCP Visit in the Last Year
from 2015 to 2019-12

Year	Percent
2015	30%
2016	28%
2017	30%
2018	33%
2019	36%

Source: CalOptima data

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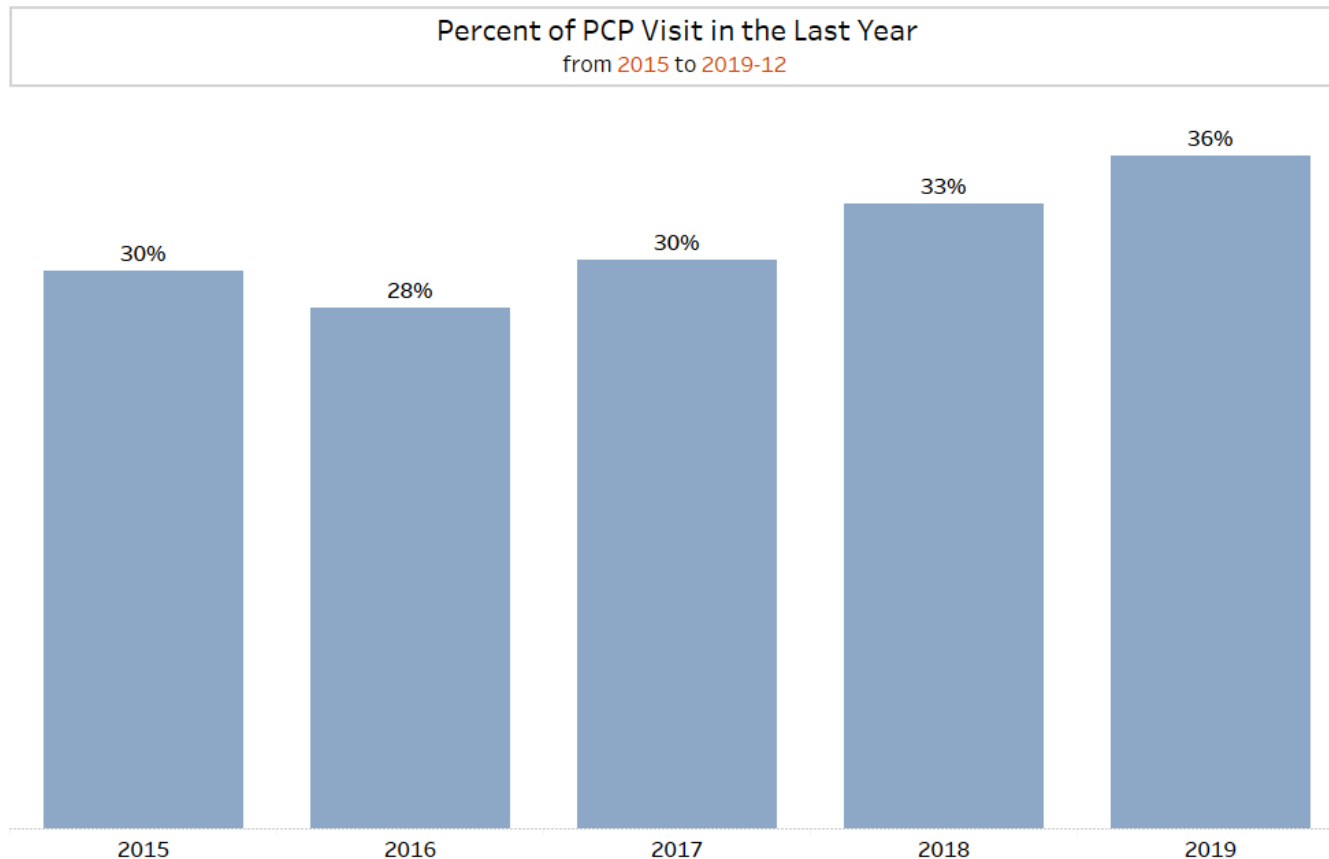
Specialist Visit Trends

- Rate of specialist visits has increased
  - Most significantly after 2017

Specialist Visit Per Member
from 2015 to 2019-12 YTD

Year	Rate	Visits
2015	1.9	12,706 Visits
2016	2.1	15,872 Visits
2017	2.8	25,540 Visits
2018	3.2	34,432 Visits
2019	3.3	38,382 Visits

Source: CalOptima data

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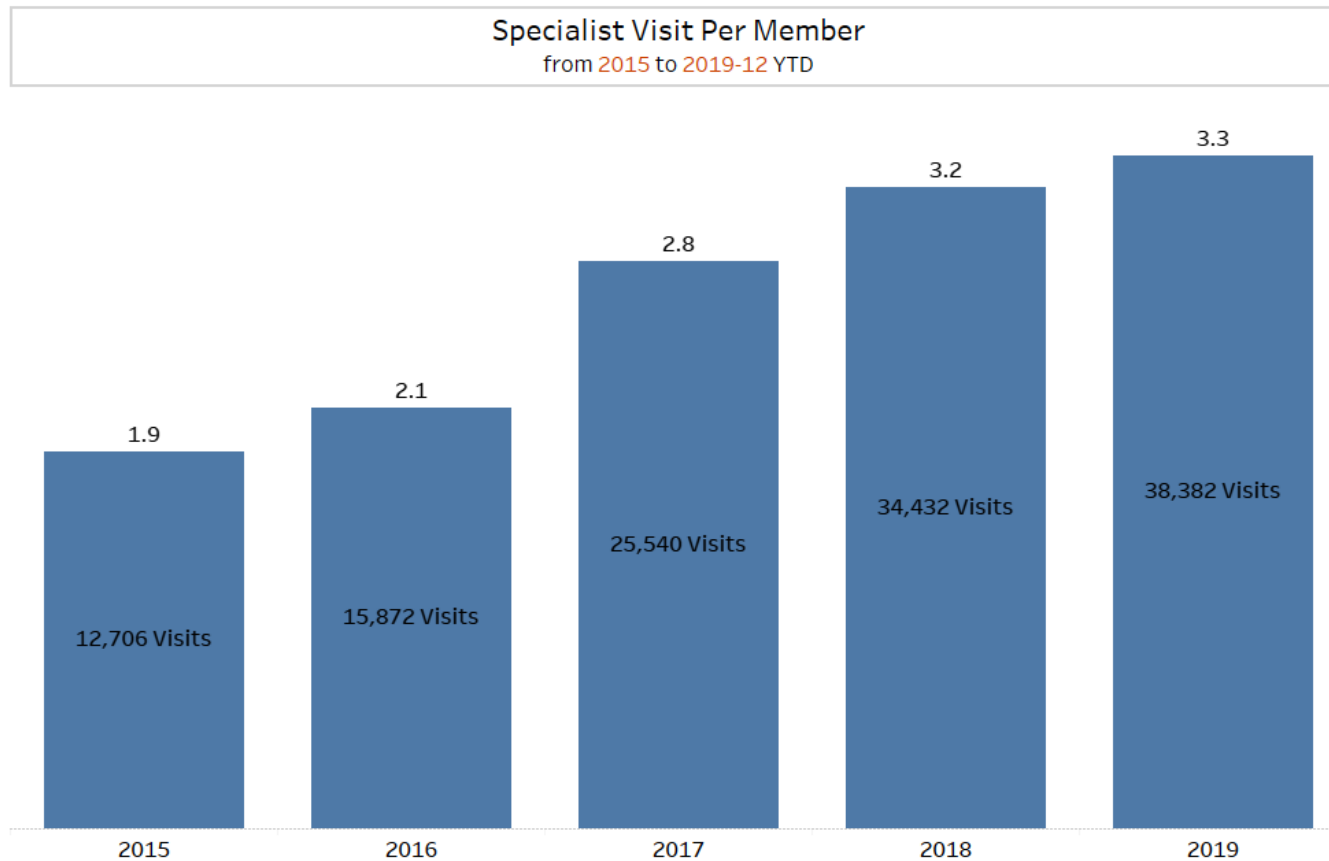
Telehealth Service Trends

- Telehealth services increased substantially
  - ➢ To support social distancing implemented during the COVID-19 pandemic
  - ➢ First case Jan 2020
  - ➢ Declared a global pandemic March 2020

Telehealth Services by Quarter
From: 2019 To: 2020 (YTD)

Telehealth Detail

	2019 Q1	2019 Q2	2019 Q4	2020 Q1	2020 Q2	Grand Total
BH	0	0	1	34	20	55
Med	0	0	1	61	53	115
Grand Total	0	0	2	95	73	170

	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2
	0	0	0	2	95	73

Source: CalOptima data

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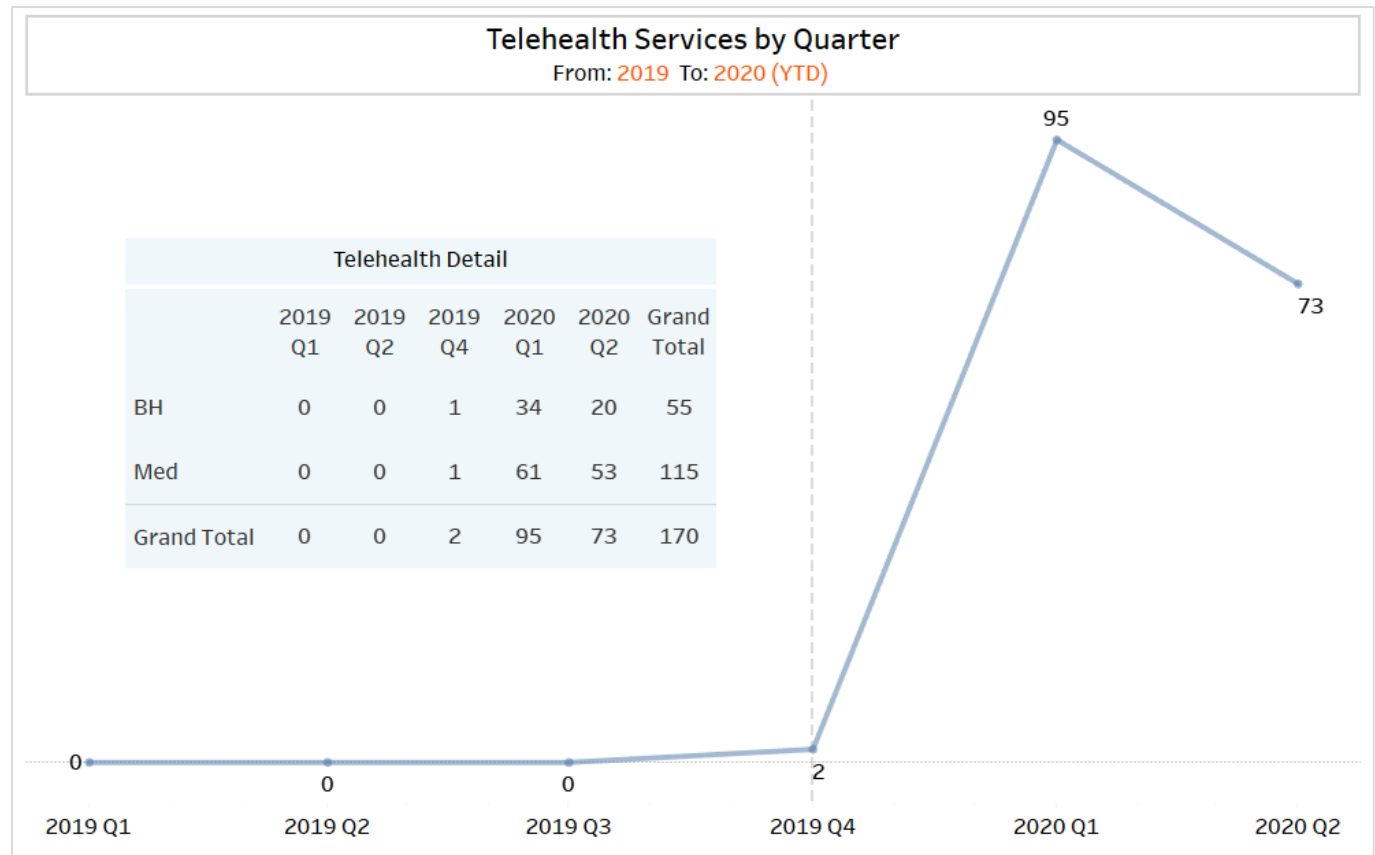
Emergency Department Trends

- ED visit rates have increased

Emergency Department Visits PTMPY
from 2015 to 2019-12 YTD

Year	PTMPY	Visits
2015	1,576	10,785 visits
2016	1,664	12,761 visits
2017	2,014	18,411 visits
2018	2,112	23,041 visits
2019	2,297	26,602 visits
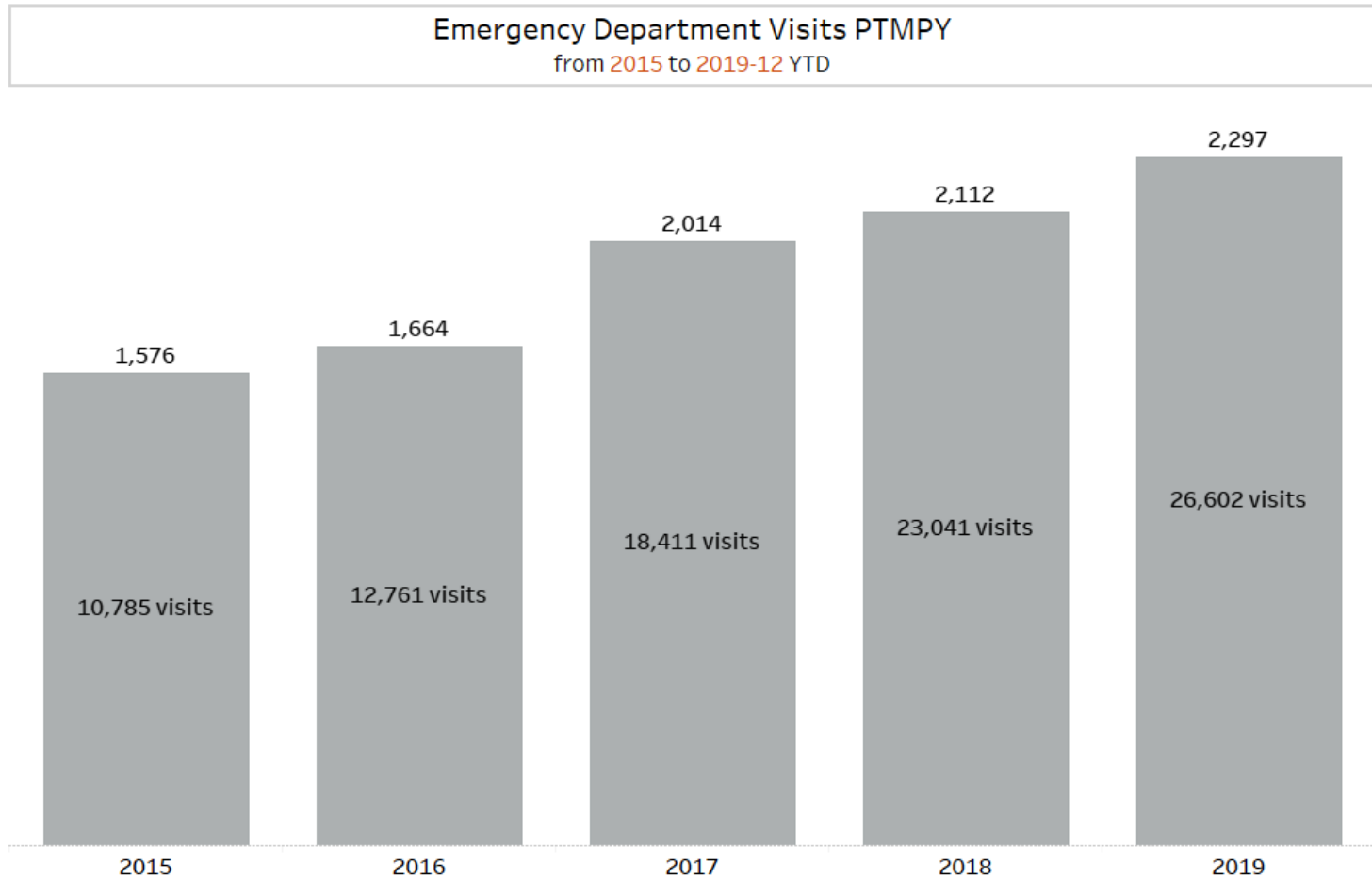
Source: CalOptima data

Inpatient Trends

- Admits per member have increased
  - ➢ Percent readmissions continues to rise

Inpatient Admits PTMPY and Percent Readmissions
from 2015 to 2019-12 YTD

Admits PTMPY: 254 (2015), 288 (2016), 389 (2017), 427 (2018), 446 (2019)

% Readmit: 20% (2015), 23% (2016), 26% (2017), 28% (2018), 31% (2019)

Source: CalOptima data

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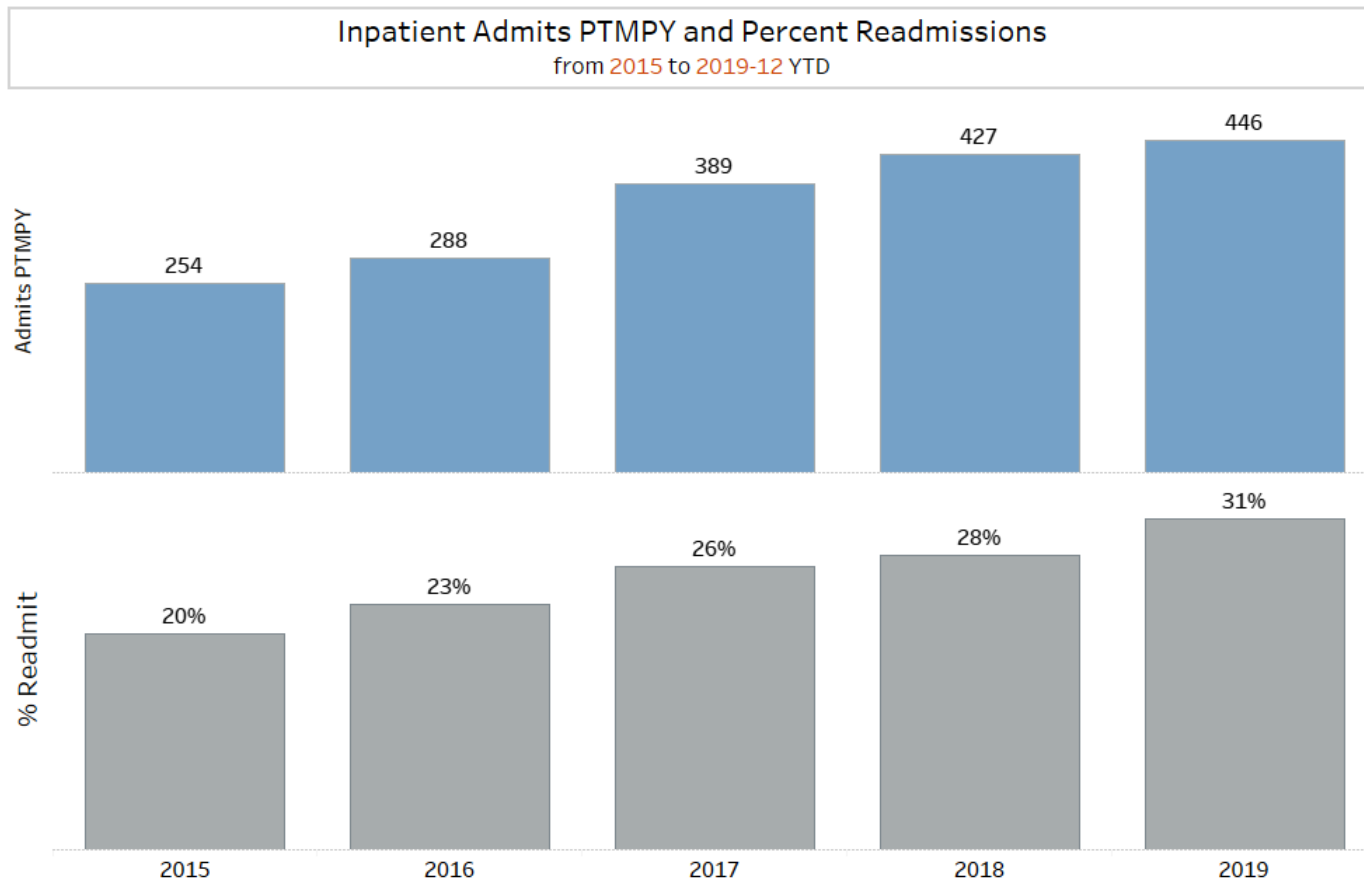
Disparities: Medical and BH Diagnoses

Comparison: Homeless and Not Homeless Populations
Top Medical and Behavioral Health Diagnoses
Prevalence diagnoses in previous 12 months

Top Medical Diagnoses

	Homeless	Not Homeless
Primary Hypertension	11%	8%
Obesity	6%	7%
Diabetes	5%	5%
Asthma	4%	3%
Acute Kidney Failure & CKD	3%	2%
Liver Disease	3%	2%
Viral Hepatitis	3%	1%
COPD	3%	1%
Heart Failure (CHF)	2%	1%
Cancer	2%	2%
High Risk / Complic. Pregnancy	1%	1%
Liver Cancer	0%	0%

Top Behavioral Diagnoses

	Homeless	Not Homeless
Substance Use Disorder	18%	3%
Anxiety Disorder	9%	4%
Depression	9%	4%
Bipolar	5%	1%
Schizophrenia	3%	0%
PTSD	2%	0%
Mood	1%	0%
Personality Disorder	1%	0%
ADHD	1%	1%
Obsessive-Compulsive	0%	0%
Eating Disorders	0%	0%

- Medical diagnoses are not significantly different in homeless and not homeless

- BH diagnoses for homeless range from two to six times higher than not homeless

Source: CalOptima data

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Summary: 2015–2019

- The number of members who are experiencing homelessness has continued to increase year over year, although at a slower rate

- Members experiencing homelessness utilize significant amounts of health care services through CalOptima

- Increase in annual PCP visit rates, specialist, emergency department, and inpatient utilization
  - Current interventions including WPC support increased member engagement with the health care system

- BH and substance abuse conditions are significantly more common in the homeless population
  - Substance abuse appears to be a factor in the majority of deaths

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Coroner's Report Monthly Cases

- Overall 50%–65% of reported coroner cases were CalOptima members
  - ➤ COVID-19 reported as contributing cause of death for 1 CalOptima member in March
  - ➤ 22 of 34 were members in April
- 48% increase in reported cases from March to April
  - ➤ Mode of death still pending for more than 60% of April cases
  - ➤ Reported modes not different than typical

All Coroners Cases: Month by Month Trend
From: January 2018 To: April 2020
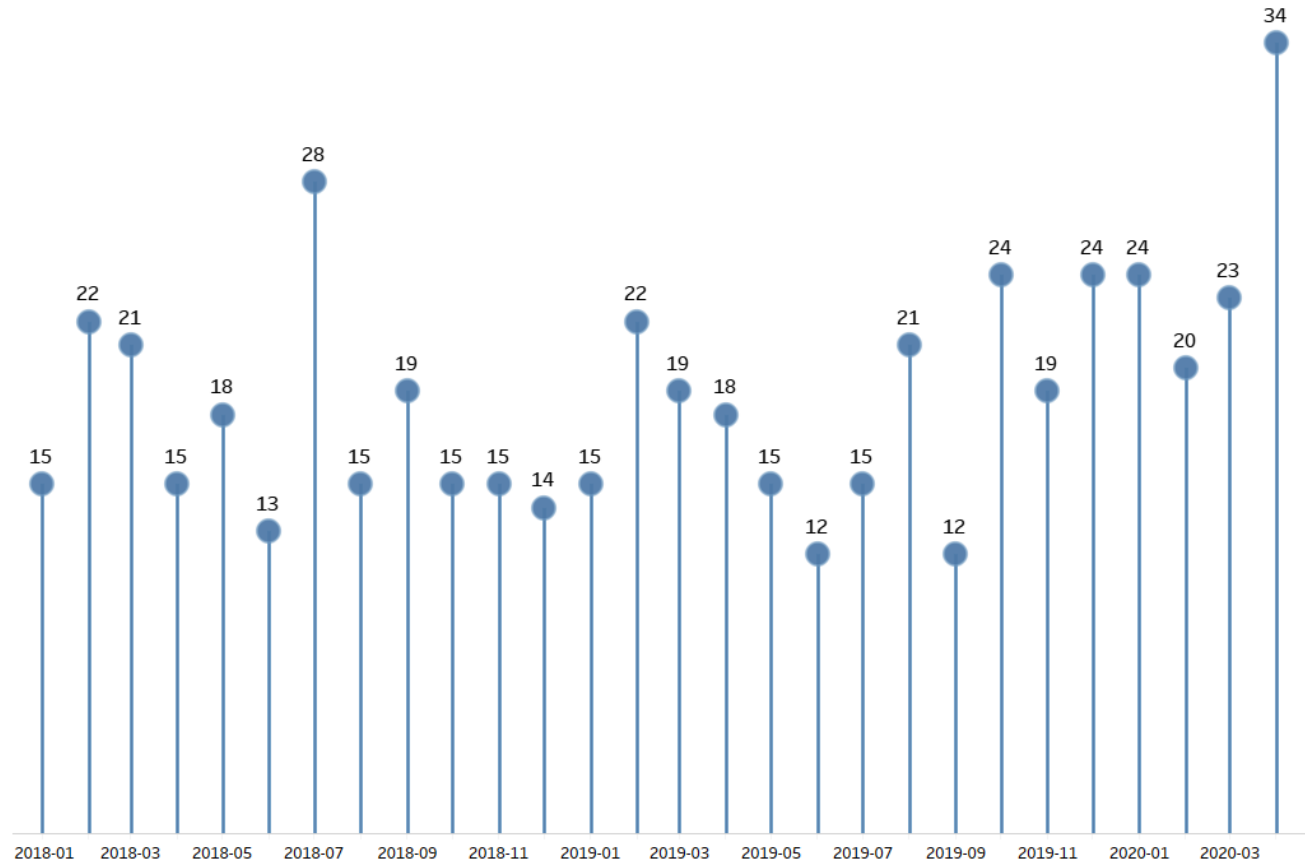
Source: Coroner's Report

Summary: 2020

- Orange County has substantially increased shelter beds and locations
  - County is providing COVID-19 testing and tracking results
  - Individuals with symptoms or positive tests are isolated to prevent spread
- CalOptima Board approved expansion of Homeless Clinical Access Program (HCAP) incentives to include CFT services and telehealth visits
  - CFT's continue to be available 6 days and 48 hours per week
- Utilization of telehealth services has increased measurably due to COVID-19 pandemic and social distancing
- Coroner's case reporting frequency has been increased to weekly (from monthly) to facilitate identification of trends

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

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Board of Directors' Quality Assurance Committee Meeting
May 20, 2020

Quality Improvement Committee (QIC) Quarter 1 2020 Update

Summary
o   QIC met on 1/14/20; 2/11/20; and 3/10/20
o   The following subcommittees reported to QIC in Q1:
  o   Behavioral Health Quality Improvement Committee (BHQIC)
  o   Whole-Child Model Clinical Advisory Committee (WCM CAC)
  o   Utilization Management Committee (UMC)
  o   Credentialing and Peer Review Committee (CPRC)
  o   Member Experience (MEMX)
  o   Grievance & Appeals Resolution Services (GARS)
  o   Program of All-Inclusive Care of the Elderly Quality Improvement Committee (PACE QIC)
o   Accepted and filed from the following committees and subcommittees:
  o   BHQIC meeting minutes: 11/19/19
  o   WCM CAC meeting minutes: 11/19/19
  o   UMC meeting minutes: 11/21/19
  o   MEMX meeting minutes: 11/5/19 and 11/20/19
  o   GARS meeting minutes: 8/21/19
  o   PACE QIC meeting minutes summary: 11/12/19 and 12/10/19; 2019 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan Evaluation; 2020 CalOptima PACE Quality Improvement Plan
  o   2019 Work Plan Dashboard Q4

QIC Highlights
  o   In January, the 2019 QI Evaluation and 2020 QI Program and Workplan were presented to QIC. In addition, the QIC charter for 2020 was reviewed and approved. The charter aligned with the QI Program as well as policy GG.1620. The Pay for Value program updates including P4V 2020 proposed payment methodology were presented and vetted at QIC. These items were presented at February QAC.
  o   **UMC** provided an update of its Q4 (October–December) metrics, which included membership summary and operational performance. Audit and Oversight department are monitoring medical authorizations. Corrective action plans have been issued as appropriate. Pharmacy and Long-term Services and Supports authorizations are meeting goals. Unused authorization performance overall average is 47%; however, UM is refining the unused authorization reporting process to determine goal or baseline. WCM reports to Department of Health Care Services (DHCS) were presented. Although a complete data set is not available yet, reports to DHCS include CalOptima Community Network (CCN) and health network (HN) data related to members in the program, continuity of care, authorizations, assessments and grievances. Monthly enhanced monitoring reports reflect challenges with care coordination, disruption of pharmacy services,

assessment challenges, barriers in pediatric health risk assessment and out of network requests for rare specialists. Custom durable medical equipment (DME) seems to be one of the areas with the most questions, and staff is working with CCS and HN training has occurred.

o **GARS** provided a summary presentation on member and provider complaints in Q3 2019. Quality of Service, Access, and Quality of Care remain the top three categories for member grievances. Member perception and expectations continue to be the main reasons for these grievances. Although access related grievances have decreased, appointment availability continues to be a pain point for members. GARS is working with the QI team to identify trends and propose recommendations with actions.

o **BHQIC** provided an update from their last BHQIC meeting, held on 11/19/2019, reporting Call Center, GARS and PQIs statistics related to behavioral health. Due to increase in staff vacancies, the call center was challenged to meet daily call demands. However, the internal referral process has been streamlined to reduce call handle time while maintaining quality of service during period of reduced staffing. Also, BH member experience survey results were shared with the committee. The overall satisfaction rate was 74.3%. The top three factors impacting satisfaction were Access to Services, Treatment Experience and Results of Treatment. ABA services had the highest average in all three areas, followed by therapy and medication management. Dr. Edwin Poon presented a new policy to QIC related to the monitoring of ABA services. The policy states that, when utilization of ABA service target is not met for two quarters, BHI may refer provider to the QI department as a Potential Quality Issue, in accordance with GG.1611. No additional referrals will be made to the provider until they can demonstrate that they are able to provide the approved services. QIC agreed with the recommendation to set ABA utilization threshold at one standard deviation below the mean.

o **Population Health Management** presented measures and incentives priorities for CalOptima's QI programs. Priorities included member incentives for preventive screenings such as breast cancer, cervical cancer and colorectal cancer. Additional focus on chronic care interventions for diabetes and cardiovascular, as well as well-child, and maternal health activities. Additional incentives were added in 2019 focused on promoting these incentives. In addition, updates on Health Risk Assessment (HRA) for Q4, which included HRA outreach and completion rates for all lines of business were presented. Various metrics related to HRA met performance goals. Performance Improvement Plans (PIPs) and CCIPs were presented. Reports included Plan All-Cause Readmission (PCR), Homeless Clinical Access Program (HCAP), Well-care Visits for children (W15), Emerging Risk, i.e. Members with A1C>8%, Statin Use for Diabetes, ICP documentation and LTC PDSA.

o **WCM CAC** provided updates from the November 19, 2019 meeting. The committee requested a dashboard of metrics, such as continuity of care, grievance and appeals, access to care, customer service, information and ER visit rate, etc. These metrics will be presented at the February 19, 2020, WCM CAC. CHOC mentioned that they are expanding their specialty appointments to accommodate reported access issues.

o **MEMX** updates included efforts directed at network certification, as well as the restructuring of the Member Experience Subcommittee. DHCS issued new guidance (APL 20-003) regarding network certification, stating MCPs' responsibility to hold delegates responsible for meeting network adequacy standards, effective 7/1/2021. Subcontracted networks will need to be certified for the following: provider to member ratios, mandatory provider types, time and distance standards, and timely access. MCPs will be required to impose CAPS on subcontracted

networks that do not meet Annual Network Certification requirements. Each MCP must submit a Plan of Action (POA) that addresses implementation efforts to meet the 7/1/2021 timeline. MEMX also discussed the restructuring of the subcommittee for 2020, focusing on two workgroups to address goals related to timely access and network adequacy.

- o **CPRC** updates include Credentialing, PQI and Facility Site Review updates. For Credentialing, there were no medical disciplinary actions taken in Q4. In summary, CCN Credentialing team processed 1,097 files with a 99% timeliness for recredentialing files. CPRC continues to review and act on issues related to medical disciplinary cause or reason, however, actions related to non-medical disciplinary cause or reason may be more appropriately handled outside the committee. Hence, an ad-hoc cross-department workgroup formed to meet and discuss contractual or quality of service issues related to specific providers. As the group is formalized, additional reports will be made to the QIC. PQI activity resulted in 1,166 cases closed, of which 35 cases were presented at CPRC. The majority of the cases were leveled with a severity code of 0 (no quality of care issue identified). Approximately 9% were leveled with a severity code of 1, 2 or 3. CPRC also reports FSR/MRR/PARS activities which include providers with failed FSR/MRR. In 2019, the FSR team completed 280 full scope and 85 initial reviews. The number of failed audits increased to 3.5% in 2019. The number of CAPS issued increased by 25% in 2019. In 2019, 462 Physical Accessibility Review Surveys (PARS) were conducted; 49% have BASIC access.

- o **QI Work Plan Dashboard Q4 2019** — Of the 45 elements being tracked on the workplan, most are on target (Green); however, about 30% are Yellow or Red, meaning there is a concern that a measure is at risk and will not meet the goal. Many of these measures will be carried over to the 2020 QI Workplan, and interventions to address the measures will be monitored.

- o **Additional new business presented in Q1 at QIC**:
  - Adverse Childhood Experience (ACE) Aware campaign promoting core training on ACE website. CalOptima Board of Directors approved $80M funding for CalOptima staff to support CME activity by Betsy Ha on 2/11/2019, and 3/10/2020.
  - Homeless Mortality Case Review Summary presented by Dr. Masatsugu on 2/11/2019, and Homeless Health Clinical Analysis update by Mary Botts on 3/10/2020
  - COVID-19 Updates
  - Proposed Telehealth Care Strategy in line with APL 19-009 by Betsy Ha on 3/10/2020
  - LTSS, presentation on CBAS Satisfaction Survey and Post-Acute Infection Prevention Quality Incentive (PIPQI), by Cathy Osborn on 3/10/2020

Attachments
1. 2019 Quality Improvement Work Plan 4Q
2. 2019 PACE Quarterly Reports Meeting Summary 4Q

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
PROGRAM OVERSIGHT							
2019 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2019 QI Program and Workplan by February 2019	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption	Betsy Ha	Approved at **QIC** 2/14/19; **QAC** 2/20/19; **BOD** on 3/7/19	None	■
2018 QI Program Evaluation	Complete Evaluation 2018 QI Program by January 2019	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	Betsy Ha	Approved at **QIC** 2/14/19; **QAC** 2/20/19	None	■
2019 UM Program	Obtain Board Approval of 2019 UM Program by Q1 2019	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption	Tracy Hitzeman	Approved at **UMC** 2/14/19; **QAC** 2/20/19; **BOD** 3/7/2019	None	■
2018 UM Program Evaluation	Complete Evaluation of 2018 UM Program by Q1 2019	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation	Tracy Hitzeman	Approved at **QIC** 2/14/19; **QAC** 2/20/19	None	■
Population Health Management Strategy	Obtain Board Approval of 2019 Population Health Management Strategy and start implementation by July 1, 2019	Implement PHM Strategy. Review and adopt on an annual basis	Annual Adoption	Betsy Ha	Approved as attachment C to the 2019 QI Program **QIC** 2/14/19; **QAC** 2/20/19; **BOD** 3/7/19.	None	■
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network per regulatory and contract requirement	Peer Review of Credentialing and Re-credentialing files, and Quality of Care and Quality of Service cases related to CalOptima's provider network.	Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC; Delegation oversight reported by A&O quarterly to CPRC.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima	CPRC met on October 24th & December 10th. CPRC reported 3Q to QIC Nov 12, 2019. Updates on Credentialing activity, Potential Quality Issues, and Facility Site Review. Shared Failed Site Reviews for July and August. CAPS were issued at the time of audit. Affiliated health networks were notified of failed scores, Training and technical assistance was provided by the FSR nurse, Evidence of corrections for CAP deficiencies verified and CAPs closed on site by FSR nurse. Annual re-audit of failed FSR or MRR. In December CPRC accepted and filed A&O credentialing/recredentialing monthly file audit results July 2019-Sept 2019.	CPRC due to report Q4 in February 2020	■

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Behavioral Health Quality Improvement Committee (BHQIC) Oversight - Conduct Internal and External oversight of BHI QI Activities per regulatory and contract requirement	Ensure member's have access to quality behavioral health services, while enhancing continuity and coordination between physical health and behavioral health providers.	BHQI meets quarterly to: monitor and identify improvement areas of member and provider services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.	Quarterly Adoption of Report	Donald Sharps MD/ Edwin Poon	BHQIC reported their 8/27/2019, 2Q meeting highlights to QIC on October 8, 2019. Included access and member experience, GARS BH Grievances , Medi-Cal Grievances , OCC Grievances, Quality and Coordination of Care: HEDIS 2019 Results Key measures including ADD, AMM, and FUH final rates were presented.

CalOptima BHT Utilization Vs. Authorization for BHT related services. | Committee recommended to add a county behavioral health provider to the Quality Improvement committee charter.

BHQI due to report Q3 to QIC January 2020. | ■ (Green) |
| **Utilization Management Committee (UMC) Oversight** - Conduct Internal and External oversight of UM Activities per regulatory and contract requirement | Monitors the utilization of health care services of CalOptima Direct and delegated HMO's, PHCS, SRGs to area identifies over and under utilization that may adversely impact the 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 | Quarterly Adoption of Report | Mike Shook | UMC reported 2Q to QIC October 8, 2019. QIC accepted and filed 8/22/2019 UMC Meeting minutes.

Membership Decresed 2.6% from prior year. Medical Auth, Pharmacy Auth and LTSS Inquiry/Auth goals were met.

Unused Authorization (current Performance 24.8%, Over/Under Utilization (no over/under utilization noted), Staff is meeting to go through quality metrics.

Utilization Outcomes Medi-Cal Measure: Goal met for Bed days, Readmissions, ED Visits.

Utilization Outcomes OCC Measure: Did not meet Goal for Bed days, ED Visits . WCM Update: Implemented reporting process and are currently collecting data per the WCM specifications and finalizing reporting process. Focus on ALOS, Bed days/K and ED | Anticipate reporting metrics at next QIC UM Update
UMC due to report Q3 to QIC January 2020. | ■ (Green) |
| **Member Experience (MEMX) Subcommittee Oversight** - Oversight of Member Experience activities to improve member experience to achieve the 2019 QI Goal | Improve member experience to meet 2019 strategic objectives. Increase CAHP performance from 25th percentile to exceed 50th percentile. | The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. | Quarterly Adoption of Report | Kelly Rex-Kimmet | MEMX reported 3Q to QIC November 12, 2019. DHCS 3Q Monitoring Unable to use 42.9% of the sample (increase from 37.1%) due to incorrect information or staff refused to participate. For those in the sample, no appointment times were collected for 20.8% (decrease from 33.3%) of non-urgent visits calls and 26.5% (decrease from 44.6%) of urgent visit calls as they were unreachable (i.e.. long hold, answering machines, no answer).

For those who an appointment could be scheduled, the percentage of CalOptima's providers who met the non-urgent wait time standard for an appointment was 62.3% (decreased from 94.8%) and 69.4% (increased from 61.3%) for an urgent appointment wait time. (Small sample size) Scores were lower for adult appointments Total N = 105 for the quarter | Awaiting final timely access report from vendor. Plan to outreach to specific providers that were identified as not answering phones during the survey outreach process. Also, workgroup will be addressing those providers who were unable to schedule appointments. | ■ (Yellow) |

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Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM per regulatory and contract requirement	Provide clinical advice for issues related to Whole Child Model.	Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	Tracy Hitzeman	WCM CAC reported Q3 updates to QIC on November 12, 2019. WCM CAC met July 15, 2019 and August 20, 2019. WCM update as of Go-Live in July 2019. HN and provider training was performed more frequent leading to and at the beginning of WCM implementation, more infrequent in the fourth quarter. The 2019 Quality Measures Crosswalk was presented. CalOptima has asked to be informed by Health Plans of any WCM clinical issues and have worked through issues that arise as they are reported. To date, the County CC3, and Whole-Child Model Family Advisory Committee have reported no unresolved WCM issues and as such, CalOptima assumes it to be well controlled.	WCM CAC committee survey was sent to request for agenda items and those will be presented at the next meeting scheduled for November 19, 2019. WCM CAC will report Q4 updates at QIC 2/11/20.	■
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals per regulatory and contract requirement	Resolve provider complaints and appeals expeditiously for all CalOptima providers in a timely manner.	The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Quarterly Adoption of Report	Ana Aranda	GARS reported 3Q Member and Provider Complaints to QIC Jnauary 14, 2019. Overall Medi-Cal and Grievances decreased in Q3. Quality of Service, Access and Quality of care continue to be main reason for grievances. There has been slight improvement in Access related issues due to improper referrals to specialists. Company-wide efforts to improve provider data may have contributed to the improvement. Also, there has been a decrease in QOC, QOS, Access and Quality of Care complaints. Members' perception and expectations continue to be the main reasons for these grievances. Although Access related grievances have decreased, appointment availability continues to be a pain point for members. Overall utiliation of Non-Medical transportation grievaances increased, NMT decreased. Medical BH , OCC Complaints decreased, OC grievances remain low.	CalOptima continues to review all grievances and appeals for: Trends, Improvements, Correction. GARS is working with the QI team in identifying these trends for further recommendations and actions. GARS to report 4Q to QIC March 2020.	■
PACE QIC - Quarterly submission PACE QIC minutes	Provide all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). Plan, coordinate and deliver the most fitting and personalized health care to participants.	The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and submitted quarterly at QIC	Quarterly Adoption of Report	Miles Masatsugu, MD	PACE Q2 & Q3 minutess were presented to QIC November 12, 2019.	4Q PACE minutes will be presented to the February QIC. Along with the 2019 PACE Evaluation, 2020 PACE QI Workplan.	■

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Quality Program Oversight - Quality Withhold	Earn 100% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2019	Quarterly monitoring and reporting to OCC Steering Committee and QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital	CalOptima is currently projected to receive 75% of the OneCare Connect Quality Withhold dollars for MY2019. However, that may change because one of the measures that we did not achieve the threshold "Controlling Blood Pressure" is likely to be suspended by CMS for CY2018 and CY2019.	Wait for CMS to send us final scores for OneCare Connect Quality Withhold dollars for MY2018 and distribute the withheld dollars to health networks.	(Green)
Quality Program Oversight - QIPE/PPME Monitoring	Meet and exceed goals set forth on the QIPE/PPE dashboard for OC/OCC measures.	Conduct quarterly oversight of specific goals on QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals	Annual Assessment	Esther Okajima/Mimi Cheung	Improvement Project updates on: **OneCare/OneCare Connec**t: *Emerging Risk CCIP* – Identifying and Intervening with Recently Identified Members with A1C >8% **OneCare Connec**t: *Statin Use for Diabetes CCIP* – Promoting Statin Use for Diabetics **ICP PIP**: Members with an Individualized Care Plan Completed/ Members with Documented Discussions of Care Goals **LTC PDSA**: Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents **HRA outreach** All LOB met outreach goals for OneCare, OneCare Connect , SPD Process change in 2020 OneCare Connect High and Low risk HRAs will follow high risk time frame of 45 days Intent is to drive up completion of care plan within 90 days of enrollment. Health Risk Assessment (PPME_QIPE) QIC 02112020\HRA Collection Stats - 2019.xlsx	Will continue reporting updates to QIC on a Quarterly basis in 2020. Will complete Table 2' in preparation for CMS Audit in 1Q 2020.	(Green)
Quality of Clinical Care							
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	OC OCC 30 day: 56% 33rd percentile OC: N/A OCC: 7 day: 28.97% 50th percentile	CalOptima to manage mental health services for OC/OCC Develop transition of care process for post-discharge Outreach to members post discharge to coordinate follow-up appointments Add ADT and/or EDIE Reporting Incentives for urgent appointments for providers	12/31/2019	Edwin Poon	PR HEDIS Rates Q4: OC 7 day: 29.41%/ Gap 75 is 2, 30 day: 52.94%/ Gap 75 is 2; OCC 7 day: 15.65%/ Gap 50 is 20, 30 day: 32.65%/ Gap 50 is 27. MBHO managed interventions (i.e., some outreach/coordination) until 12/31/19. CalOptima directly managing LOB as of 1/1/2020. Directors met with high volume hospitals to edcuate on transition and new process. Transition of care management team created and building relationships with hospitals. CalOptima working with OC HCA to ensure that all County claims are being processed to fully capture all data.	Continuing to look at ways to improve follow-up after hospitalization (e.g., develop CORE to pull follow up appointment data from Guiding Care script). Looking at pilot program for DHCS' BHI Incentive Program.	(Yellow)

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Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	MC: 79.67% 50th percentile OC: N/A OCC: 90.23% 50th percentile	Targeted outreach of CCN	12/31/2019	Pshyra Jones/ Nicki Ghazanfarpour	November 2019 Prospective Rates for PBH MC PBH 74.43% @ 25th percentile; MC CCN PBH 814.29% @ 75th percentile; OC PBH 100% @ over 90th percentile; OCC PBH 81.48% below 25th percentile PBH Faxes: 160; Successful: 150; Failed: 10 (faxes); 266 (members); Total Mbr count: MCAL=231; OCC= 34; OC= 1	Continue Provider fax campaign quarterly.	■ (Green)
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.	MC; Continuation Phase: 45% 50th percentile	Targeted outreach of CCN Develop a process for member outreach and/or coordination	12/31/2019	Edwin Poon	PR HEDIS Rates Q4: Initiation Phase: 42.02% Gap to 50th is 39; Continuation and Maintenance Phase: 44.62% Gap to 50th is 32. Pharmacy implemented 30-day limit on refill of Rx in order for member to attend a follow-up with provider past 30 days for a refill. CORE report to identify members and their providers completed.	Plan to address members and providers through outreach and assistance with appointment setting and reminders is pending due to limited resources.	■ (Yellow)
Improve HEDIS measures related to Asthma: Asthma Medication Ratio (AMR)	MC: 65.30% 66th percentile	Targeted outreach of CCN	12/31/2019	Pshyra Jones/Helen Syn	November AMR Prospective Rate (PR): Total (5-64 years) = 95.42% @ 90th percentile. Monitoring measure. MR was not seen as an area where intervention was currently needed since the national threshold was met/exceeded.	Continue to monitor measure	■ (Green)
Plan All-Cause Readmissions (PCR)	MC: N/A OC: 8% 50th percentile OCC: 10%	Update Transition of Care post-discharge program, all diagnosis for all LOB (Focus on Anaheim and Fountain Valley hospitals) New means of identification for ER visits in Data Warehouse. CMS: CCN OCC Members with CHF and hospital admission. Health Coaches contact member to prevent unplanned readmission within 30 days (all hospitals excluding Anaheim and Fountain Valley)	12/31/2019	Sloane Petrillo/ Pam Neale Joanne/Melanie Helen Syn/ Jocelyn Johnson	Complex and multi-departmental measure, Vendors selected for hospital data exchange, Implementation date pending, Health Network best practices	Awaiting Identification for ER visits in Data Warehouse through a new vendor. CMS: CCN OCC members with CHF and hospital admission. Health Coaches contact member to prevent unplanned readmission within 30 days Work with Office Ally to incorporate their EMR into CalOptima data warehouse for offices that are contracted with both entities.	■ (Yellow)

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Improving the quality performance of all HNs, including CalOptima Community Network (CCN).	Implement practice transformation technical assistance in 5 high volume CCN practices by December 2019 Expand provider coaching and customer service training to include all health networks, and PQI Providers and CCN office staff by December 2019	Pay for Value Provider Report Card Provider Incentive targeting measures not in P4V Practice Transformation Initiative in partnership with California Quality Coalition Expand provider coaching and customer service training	12/31/2019	Kelly Rex-Kimmet / Esther Okajima	Pay for Value (P4V) program has generated quarterly CCN Provider Report Cards for all P4V clinical measures and made the reports available to all CCN providers through the CalOptima Provider Portal. P4V team has participated in several meetings hosted by the Provider Relations program to provide an overview to CCN providers and their staff on how to access the Report Cards from the Provider Portal, as well as to interpret their performance for each clinical measure. CalOptima is working to extend the contract with SullivanLuillan to provider provider coaching and customer service trainings.	Pay for Value team will continue to generate the Provider Report Cards and work with the CCN providers to improve their performance on each clinical measure and thereby, improve the overall performance and ranking of CCN as a health network. Upon execution of the amended with SullivanLuillan, QA will promote services to physicians and provider offices.	Green
Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	MC: 75.84% 25th percentile	Promotion of preventive care services to improve AAP measures.	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	**November AAP Prospective Rate (PR):** **MC:** (20-44 years): 59.42% below 25th percentile (45-64 years): 76.17% below 25th percentile (65+): 84.87% @ 25th percentile (All): 67.66% below 25th percentile All submeasures are performing better compared to same time last year. **OC (All):** 91.08% below 25th percentile **OCC: (All):** 89.42% below 25th percentile	Continue to promote preventive care screenings and incentive programs for well care and EPSDT visits.	Yellow
Cervical Cancer Screening (CCS)	MC: 63.26% 66th percentile	Promotion of member incentive programs. $25 gift card for cervical cancer screening	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	Continue promotion of the $25 cervical cancer screening member incentive. Incentive was shared with health networks to promote at point of service and aligned with HN campaigns. **# of CCS 2019 member incentives paid out as of 2/5/2020: 853** Incentive is gaining awareness and being more actively promoted to Health Networks directly. **November Prospective Rate (PR):** MC 58.13% @ 25th percentile Measure is performing better than same time last year.	Promote CCS member incentive program via health networks, CCN network, website and community organizations.	Green

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Colorectal Cancer Screening (COL)	OC: 4 STAR OCC: 3 STAR	Set up $50 per screening incentive for OC/OCC	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	**November Prospective Rate (PR):** OC: 56.35% below 25th percentile OCC: 54.80% below 25th percentile Measure is performing better than same time last year.	$50 colorectal cancer screening member incentive will be offered to OC/OCC members starting 2020. Members must completed a sigmoidoscopy/ colonoscopy to qualify for the incentive.	(green)
Breast Cancer Screening (BCS)	MC: 65.30% 75th percentile	Mobile Mammography Continue existing incentives	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	Continue promotion of the Medi-Cal $25 breast cancer screening member incentive. Incentive was shared with health networks to promote at point of service and aligned with HN campaigns. **# of BCS 2019 member incentives paid out as of 2/5/2020: 752** **November Prospective Rate (PR):** MC: 60.5%; @ 50th percentile OC: 66.85% ; close to 50th percentile OCC: 63.65%; @25th percentile	Breast cancer screening member incentive will expand to OC/OCC LOB starting 2020. Promote member incentive program via health networks, CCN network, website and community organizations.	(green)
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	MC; 27.63% 25th percentile	Provider Education outreach	12/31/2019	Pshyra Jones/Mimi Cheung	AAB is no longer a MPL measure for DHCS. AAB is still a NCQA measure. **November Prospective Rate (PR): MC** 29.7% @ 25th percentile Measure is performing better when compared to same time last year.	Prospective rates remain low. Continue to monitor measure, through 2020 QI Workplan, and develop interventions for 2020.	(yellow)

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Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)	Therapy OC:74% 66th percentile OCC:74% 66th percentile Adherence OC: 80.75% 75th percentile OCC: 74.56% 50th percentile	SPD provider quarterly faxes SPD targeted member mailing	12/31/2019	Pshyra Jones/Helen Syn/ Nicki Ghazanfarpour	November Prospective (PR): 1) MC SPC: Therapy Total: 75.73%; Adherence Total: 58.88% both @ 25th percentile MC SPD Therapy Total: 68.99% @ 90th percentile; Adherence Total: 58.05% @ 25th percentile 2) OC SPC Therapy Total:74.42% ; Adherence Total: 62.5% both below 25th percentile OC SPDTherapy Total: 70.0% @ 25th percentile; Adherence Total: 65.31% below 25th percentile 3) OCC SPC Therapy Total: 75.79% below 25th percentile ; Adherence Total: 68.71%; below 25th percentile OCC SPD Therapy Total: 74.7% @ 25th percentile ; Adherence Total: 70.46% @ 50th percentile Provider fax interventions completed by Pharmacy Dept for SPD: 655; Successful: 597; Failed: 58 (faxes); 8,603 (members) Total Mbr Count: MCAL: 7,858; OCC: 726; OC: 19 Provider fax interventions completed by Pharmacy Dept for SPC: SPC Faxes: 333 ; Successful: 309; Failed: 24 (faxes); 956 (members); Total Mbr Count: MCAL: 796; OCC: 147; OC: 13 SPD targeted member mailings dropped on 12/9/19 (Arabic, Chinese, Farsi and Korean): MC = 95, OCC = 7	Continue with SPD member mailings. English, Spanish and Vietnamese mailings will drop in January, 2020. Continue with SPD SPC non-compliant faxes to providers	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	**A1c Testing:** MC: 91.58% 75th percentile OC: 92.15% 25th percentile OCC: 92.15% 25th percentile	$25 Medi-Cal member incentive PIP CDC	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	**# of Diabetes A1C Testing 2019 member incentives paid out as of 2/5/2020 from June to Dec 2019: 521** 2019 Medi-Cal A1C incentive was mailed to a limited targeted population, launch date June 2019 **November Prospective Rates (PR):** MC CDC A1C Testing - 85.32% @ 25th percentile Measure is performing better when compared to same time last year. OC CDC A1C Testing - 88.19% below 25th percentile OCC CDC A1C Testing - 89.26% below 25th percentile	Promote A1c testing Medi-Cal member incentive program via health networks, CCN network, website and community organizations.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	A1c (<8%): MC: 59.49% 90th percentile OC: 77.26% 66th percentile OCC: 71.29% 66th percentile	PIP - CDC	12/31/2019	Pshyra Jones/ Dr. Dajee/ Helen Syn/ Mimi Cheung	**November Prospective Rates (PR):** All below 25th percentile MC CDC - HbA1c Poor Control (>9%): 65.78% MC CDC - HbA1c Adequate Control (<8%) 28.41% OC CDC - HbA1c Poor Control (>9%) 54.51% OC CDC - HbA1c Adequate Control (<8%) 40.63% Measure is performing better when compared to the same time last year. OCC CDC - HbA1c Poor Control (>9%) 56.82 % OCC CDC - HbA1c Adequate Control (<8%) 37.22% Measure is performing lower when compared to the same time last year.	The quality improvement program concluded in 2019 but value-added interventions and other strategies are being discussed for 2020.	

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Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	Eye Exams: MC: 66.42% 75th percentile OC: 80% 66th percentile OCC: 80% 66th percentile	$25 Member Incentive for diabetic eye exam. Expand annual access to VSP to MC Diabetic members	12/31/2019	Pshyra Jones/Helen Syn	**# of Diabetes Eye Exam 2019 member incentives paid out as of 2/5/2020 from June to Dec 2019: 167** 2019 eye exam Medi-Cal incentive was mailed to a limited targeted population, launch date June 2019. Limitations identified due to VSP eligiblity file not indicating diabetic members eligible for annual eye exam. **November Prospective Rates (PR):** MC CDC Eye Exams - 55.22% @ 25th percentile Measure is performing better when compared to same time last year. OC CDC Eye Exams - 57.29% below 25th percentile OCC CDC Eye Exams - 68.68% @ 25th percentile	VSP eligibility file to have diabetic members identified as eligible for annual exam - in progress with IS. Promote diabetic eye exam member incentive program via health networks, CCN network, website and community organizations.	(yellow)
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	Nephropathy: MC: 92.05% 75th percentile OC: 95% 25th percentile OCC 97% 66th percentile	PIP - CDC	12/31/2019	Pshyra Jones/Helen Syn	**November Prospective Rates (PR):** MC CDC Nephropathy 90.29% - @ 25th percentile OC CDC Nephropathy 92.36% below 25th percentile OCC CDC Nephropathy 94.97% @ 25th percentile Monitoring measure due to not being deemed a priority measure; no current interventions planned.	Continue to monitor measure, may need to revisit if do not meet performance standards.	(yellow)
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	Prenatal: 87.06% 75th percentile Postpartum: 73.97% 90th percentile	Increase PPC from existing $25 to $50 Conduct Bright Step post partum assessment	12/31/2019	Pshyra Jones/ Ann Mino	1) Postpartum Care (PPC) Member incentive: **# of PPC 2019 member incentives paid out as of 2/5/2020: 147** The incentive is gaining awareness and being more actively promoted to Health Networks directly. **Postpartum Care (PPC) November Prospective Rate**: 54.8%	Promote PPC member incentive program via health networks, CCN network, website and community organizations.	(yellow)
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	Continuation Phase: MC: 42.31% 75th Percentile OC: 67.87% 90th percentile OCC: 49% 25th percentile	Proposed Incentive for 2 follow-up incentives within 6 months: AMM $75	12/31/2019	Edwin Poon	PR HEDIS Rates Q4: Medi-Cal Initiation Phase: 59.20%/ Gap 90 is 390, Continuation and Maintenance Phase: 42.43%/ Gap 90 is 481; OC Initiation Phase: 72.73%/ Gap 75 is 1, Continuation and Maintenance Phase: 54.55%/ Gap 75 is 2; OCC Initiation Phase: 72.78%/ Gap 75 is 7, Continuation and Maintenance Phase: 55.30%/ Gap 75 is 16. No active intervention, however trend continues to maintain above 50%.	Continue to look at potential impact from DSF.	(green)

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Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)	New in 2019, DHCS required, for MC, no external benchmarks	Proposed Incentive f/u visit within 30 days for those who screen positive: DSF $25	12/31/2019	Edwin Poon	HEDIS specifications changed this year. No data available for this measure at this time. Meetings occurred to look at ways to capture HNA PHQ scores from Guiding Care for WCM population.	Began loading PHQ2 scores from Guiding Care that can be uploaded to HEDIS software. Continue exploring ways to gather data from other populations.	RED
Childhood Immunization Status (CIS): Combo 10	MC: Combo 10: 48.42% 90th percentile Last year final rate 45.01 75%, our goal is to move from 75% to 90%	CalOptima Days targeting W15 measure W15 Incentive, $100 completed 6 visits in 12 month or $50 for first month, and $100 for completing	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1)** Held W15-specific CalOptima Day events at 3 high volume provider offices with multiple locations . **2)** W15 incentive drop 9/1/19 to targeted members who are due and can impact HEDIS 2020. **3)** Targeted W15 call campaign to promote the 5 and/or 6 visits for members in HEDIS 2020. (Sept-Oct) **CIS Combo 10 November (PR):** 31.49 % @ 25th percentile Measure is performing better than same time last year. However, currently below the 10th percentile for 2019 HEDIS final rate. Measure is at risk for falling below the MPL. **GOAL: 35.28% (50th percentile)**	Continue promoting well-care visits and immunizations for members 0-15 months. Promote W15 member and provider incentive programs for 2020 which would impact IZ measure. Ad Hoc CalOptima Events scheduled for high volume offices specifically for W15 measure.	YELLOW
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	MC: 83.70% 90th percentile	CalOptima Days targeting adults and children	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	Developed and mailed Health Guides **November September Prospective Rate (PR):** 64.53% below 25th percentile Measure is performing better when compared to the same time last year. This is a DHCS MPL measure. May not meet the 50th percentile goal of 73.89%.	Continue promoting well-care visits and immunizations for members 3-6 years. Will need to revisit if fall below MPL.	RED

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2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Well-Care Visits in first 15 months of life (W15)	MC: 58.54% 25th percentile	CalOptima Days targeting adults and children W15 Incentive, $100 completed 6 visits in 12 month or $50 for first month, and $100 for completing	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Held W15-specific CalOptima Day events at 3 high volume provider offices with multiple locations 2) W15 incentive drop 9/1/19 to targeted members who are due and can impact HEDIS 2020. Incentive Payout (Sept - December, 2019): 221 member incentive approved for payment 3) Targeted W15 call campaign to promote the 5 and/or 6 visits for members in HEDIS 2020. (Sept-Oct) **# of W15 2019 member incentives paid out as of 2/5/2020 for Sept-Dec 2019: 247** **W15 November (PR) All 6 well-child visits:** 39.49% below 25th percentile Measure is performing better than same time last year. However, currently below the 10th percentile for 2019 HEDIS final rate. Measure is at risk for falling below the MPL. **GOAL: 66.23% (50th percentile)**	Continue promoting well-care visits and immunizations for members 0-15 months. Promote W15 member and provider incentive programs for 2020 which would impact IZ measure. Ad Hoc CalOptima Events scheduled for high volume offices specifically for W15 measure.	RED
Adolescent Well-Care Visits (AWC)	MC: 54.57% 50th percentile	AWC incentive, $25/visit targeting 12-17 year olds	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) $25 or movie tickets AWC member incentive to launch in 2020. 2)Developed Health Guides with immunization and well child schedules for adolescents. Promote well-care using other social media platforms and web site. **November Prospective Rate (PR): 43.99%** below 25th percentile. Measure is at risk for falling below the MPL. GOAL: 54.57% (50th percentile)	Continue promoting well-care visits and immunizations for members 0-21 years. Promote new 2020 AWC member incentive program via health networks, CCN network, website and community organizations.	RED
Appropriate Testing for Children with Pharyngitis (CWP)	MC: 72.52% 25th percentile	Monitoring measure	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	Monitor measure. Recommend to remove from QI work plan as it is not a priority measure **November Prospective Rate (PR):** 68.81% below 25th percentile	Monitor measure	GREEN
Children and Adolescents' Access to Primary Care Practitioners (CAP)	MC 12-24 Months 93.64% 25-6 years: 89.26% 7-11 years: 90.69% 12-19 years: 89.56% 50th percentile	CalOptima Days targeting adults and children AWC incentive, $25/visit targeting 12-15 year olds W15 Incentive, $100 completed 6 visits in 12 month or $50 for first month, and $100 for completing	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	Continue with targeted CalOptima Day events for the W15 measures. Developed Health Guides for ages 0-21. Developed member incentives for W15 measure starting 2019 and to launch new incentives for 2020. Promote well-care using other social media platforms and web site. All activities support the CAP measures. **November Prospective Rate (PR):** - 12-24 months: 93.46% below 25th percentile - 25-6 years: 83.59% below 25th percentile - 7-11 years: 90.20% @ 25th percentile - 12-19 years (P4V): 87.68% @ 25th percentile All submeasures performing better than the same time last year.	Continue promoting well-care visits and immunizations for members 0-19 years. Promote new and existing member incentive programs for 2020.	YELLOW

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2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Quality of Service							
Review and Report GARS for all Lines of Business, Include review of quality issues (QOC, QOS, Access) related to member "pain points" and provide recommendation to assure appropriate actions are taken to improve member experience.	Address quality issues related to (Quality of Service, Access, and Quality of Care).	Provider Data Initiative to address accuracy issues with on-line provider directory which may impact member experience Provider Coaching Initiative	12/31/2019	Marsha Choo	In Q4, 2019, CalOptima amended the contract with SullivanLuillan to offer provider coaching and customer service workshops to providers and their offices. Promoted these services at the HN Forum and will be working with FSR nurses and provider relations staff to promote these services to providers during their office visits. Identified 8 providers with a higher rate of grievances than their peers and offered these services as part of the notification letter. In 2019, there were 21 providers who participated in the shadow coaching. And 6 workshops (3 for staff and 3 for supervisor/management) were held on how to improve customer service. The feedback from these sessions has been very positive and CalOptima will be continuing this activity in 2020. CalOptima focused their efforts on improving access by making updates to the provider directory. Quarterly, DHCS provides CalOptima with feedback and data on the 274 file and the provider directory. Staff will work to validate this provider information and make updates in PDMS and the provider directory when needed. In Q4, 'urgent care' services were made more easily searchable in the online provider directory. Both the DHCS quarterly reports, the Timely Access Survey and greivances have identified that provider office are not answering the phone timely. The Access and Availabiltiy will focus on this area in the next quarter.	Provider relations staff and FSR nurses to continue promoting coaching and workshops. QA staff will work to schedule sessions for S&L to conduct these services at provider office. Staff will continue to validate provider information using files from both DHCS and our internal Timely Access Survey. The provider directory will also be updated so that 'urgent care' service will be visible at the top of the website page.	(yellow)

4Q

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Safety of Clinical Care							
Pharmacy Utilization Performance: Opioid Analgesics	Promote optimal utilization of opioid analgesics.	Formulary Management quarterly meetings a. Quantity limits b. Duration limits c. Prior Authorization criteria d. Prescriber Report Cards	12/31/2019	Kris Gericke	QTR 1: 15.6 QTR 2: 15.1 QTR 3: 14.8 QTR 4: 12.3	Goal met. Continue interventions and monitoring.	Green
Follow-up on Potential Quality Of Care Complaints	To assure patient safety and enhance patient experience by timeliness of clinical care reviews	Provider Report Card Expand Provider Coaching	12/31/2019	Laura Guest	In Q4, trend data for PQIs and grievances was run for all practitioners. Those practitioners who had >= 25 grievances and a rate that was 5 times greater than the specialty for 2 years, were identified. Two were identified as new and will be re-reviewed in 6 months. Twenty providers were identifed in Q3 2018 and repeated on the current list. Each of these providers will receive letter which will again offer provider coaching. Eight of these providers were addressed at the Provider Ad Hoc work group for further action because their rates and volume of grievances were so much greater than their peers. Another twenty-three providers were new to the list and will receive a letter offering the provider coaching for the first time.	We will continue to monitor the grievances every 6 months.	Green
Member Experience							
Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	Improve Member Experience for **Getting Needed Care** from 25th to 50th percentile AND Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	Update and redesign P4V CalOptima Days for Specialists as well as PCPs Create Access incentives for hard to access specialties to accept new referrals Member Portal Implementation Streamline CCN Prior Auth Process: i.e. change feed from COLA to GC, update auto auth, Provider Directory Initiative, notification to members of approved auths, unused	12/31/2019	Marsha Choo	Mailed out overcapacity letters to 34 providers and notified their affiliated health networks in September and closed 24 provider due to overcapacity. Since the beginning of PCP monitoring, and the number of PCP who are overcapcity decreased from 24 to 19. CalOptima held 3 CalOptima Days with PCPs in Q4 and 26 were held during 2019. CalOptima presented the HN Quality Rating program to the Board of Director's November Finance and Audit Committee and December Quality Assurance Committee. The HN Quality Rating is proposed to drive future P4V payments with a significant portion of the HN quality rating dependent upon excellent member experience scores. CalOptima developed and launched the CCN PCP report card and has started posting the results to the provider portal for CCN PCPs. The CCN report card includes information for each provider regarding over-capacity member assignments. The Member Portal was soft launched in April 2019 for members in all LOBs and Release 3 was deployed in November with the following updates: • Spanish language support (initial launch was English only), • Enhanced registration for Member Personal Representatives. This allows parents to register their children under 18 years of age and personal representatives to register on member's behalf)., • Multiple code updates to ensure functionality with new FACETs upgrade. CalOptima also reviewed the current auto-authorization rules. There was a total of 107 Auto Authorization rules in Cerecons. In March 2019, the UM team started reviewing these rules to ensure accuracy and to evaluate if they were working as anticipated.	Send out quarterly provider and network letters on overcapacity. Focus initiatives and resources in 2020 for improving Timely Access/Appointment Availability, and Network Adequacy. HN Rating Program will be presented to the Board of Directors Meeting in early 2020.	Yellow

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2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Compliance							
Delegation Oversight of HN Compliance (UM, CR, Claims)	Delegation Oversight of Health Networks to assess compliance of **UM, CR, Claims**	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations; Credentialing, Claims etc. **Report from AOC	12/31/2019	Solange Marvin	Reported to AOC	Please refer to AOC for corrective actions issued	
HN Compliance with CCM NCQA Standards	Delegation Oversight of Health Networks to assess compliance of **CCM**	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as CCM; **Report from AOC	12/31/2019	Sloane Petrillo	Reported to AOC	Please refer to AOC for corrective actions issued	

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Board of Director's Quality Assurance Committee Meeting
May 20, 2020
Program of All Inclusive-Care for the Elderly Quality Improvement Committee (PQIC)
Quarter 4 2019 Meeting Summaries

PQIC Meeting Dates: November 12, 2019, (Review of Health Plan Management System [HPMS] Data Submission) and December 10, 2019, (Review of PACE Quality Improvement [QI] Indicators). All PQIC members present.

November 12, 2019: Review of HPMS Data Submission and PACE Quality Initiatives; PACE Infection Control Subcommittee

- o Infection Control Subcommittee: Tuberculosis (TB) exposure update provided. Staff is working with the Orange County Health Care Agency in testing participants and employees who may have been exposed to an active case of TB.
- o HPMS Data Submission included PowerPoint slides of the reported data elements:
  - Membership: Numbers are in line with our enrollment goals. Discussions centered around preparation for projected growth, specifically, personnel and workstations.
  - Immunizations: Flu Vaccine Campaign is active in the PACE Clinic. The goal is to meet 100% vaccination rate. We experienced a delay in receiving some vaccines from the supplier. We have a 95% vaccination rate for the pneumococcal vaccine.
  - Falls without Injury: Numbers have risen slightly from the previous quarter. Many of the falls are recurring falls for specific participants who are not using their durable medical equipment. Discussion ensued around moving some of these participants into long-term care for safety reasons. We will continue to look at trends and identify interventions.
  - Appeals and Grievances: Numbers are low for participants filing grievances and appeals. The majority of grievances revolved around transportation issues (e.g., late pick-ups) and most appeals revolve around requests for more center attendance days. As an action item, PACE QI department staff will conduct quarterly ride alongs with the transportation department as an oversight measure.
  - Medication Errors: Three errors were reported during the Flu Vaccine Campaign. All involved not using the age-appropriate vaccine. No adverse reactions were noted; staff was counseled, and no further incidents have occurred.
  - Unusual Incidents: Eight falls with Injury were reported for previous quarter with most of the falls occurring at the participant's home. Root Cause Analyses are conducted for each unusual incident.
- o Quality Initiatives: Updates on PACE's three Quality Initiatives were provided:
  - PACE 2.0 which addresses program growth, capacity building and employee engagement shows that enrollment has trended up, and we are ahead of the curve. Conversion rate from inquiry to enrollment increased.
  - Care Plans: Care Plan reviews noted that we need to improve upon coding.
  - Clinical Service Requests: The Clinic implemented a new triage process, which is going well and improving participant satisfaction.

December 10, 2019: Review of PACE QI Indicators; PACE Infection Control Subcommittee

- o Infection Control Subcommittee: A TB Exposure update was provided. With 96% of the participants completed Phase 1 of 2 testing.
- o Improve the Quality of Care for Participants:
    - Immunizations: One-on-one visits are being scheduled for those participants who are refusing the pneumococcal vaccine. We are still actively vaccinating against influenza.
    - Respiratory Infection Rates: We are well below the national benchmark.
    - Provider Orders for Life-Sustaining Treatment (POLST): We have 100% of the participants with a POLST.
    - Functional Assessments: A couple of participants had moved out of the service area and, as a result, did not have their assessment completed.
    - Comprehensive Diabetes Care: We are above goal in blood pressure control and diabetic eye exams. We fell slightly below goal (less than 1%) in nephropathy monitoring. Our clinical medical director explained that appropriate tests have now been ordered and some participants have had a change in their medication.
    - Drug-Disease Interaction in the Elderly: Outcomes are good. The pharmacist is involved in Care Plan discussions.
    - Medication Reconciliation Post-Discharge: We are above goal in this indicator.
- o Ensure Safety of Clinical Care:
    - Use of Opioids at High Dosages: Four participants fall into this category. All have had a follow-up with their primary care provider (PCP).
    - Day Center Falls: Five falls were reported for the previous quarter. Falls occurred in either the activity room, the clinic or the bathroom. We will begin to run this data by site, which would include the alternative care sites.
- o Ensure Appropriate Use of Resources:
    - Access to Specialty Care: Due to PACE growth and a decrease in staff, we fell below our goal. It was reported that new staff members were hired. Our clinical medical director is working on securing a stable specialist panel for more expedient consults.
    - Hospital/Emergency Room/Readmissions Utilization: The clinical medical director shared that non-compliance is the major reason for utilization issues. Family disengagement is another contributing factor. Discussion ensued around the topic of family involvement and end-of-life care at the time of enrollment. The PCP will be driving the discussion of high-risk/high utilizers during Interdisciplinary Team (IDT) meetings. The clinical medical director will examine the need for custodial care as an alternative to hospitalization and other ways to reduce utilization.
    - Long-Term Care: We have 1% of the participants in long-term care, which is below the state average.
- o Improve Participant Experience:
    - Membership: We are meeting our goal. Discussion followed around availability of exam rooms.
    - Enrollment/Disenrollment: Disenrollment rates are at 6%, which is below our goal. We are working on examining the data of inquiry to enrollment versus qualified lead to enrollment.
    - Transportation: On-time performance is more than 96%. We have approximately 6,000 one-way rides per month. QI staff accompanied one driver and reported that the trip was in accordance with the one-hour time rule. The PACE Director stated that there will be some changes within the Transportation department in January 2020.

- Meal Satisfaction: We are looking at different vendors to improve meal satisfaction for the participants. Our social workers will continue to survey the participants during their reassessments.
  - o Summary/Priorities and Resource Allocation: PCPs will begin to interact with specialists. We will add another IDT Team (for a total of four). IDT meetings will be physician driven.
  - o PACE Desk References: Five new desk references were presented and approved by the committee.

Member Trend Report: Fourth Quarter 2019

Board of Directors' Quality Assurance Committee Meeting

May 20, 2020

Ana Aranda

Director, Grievance and Appeals Resolution Services

Overview

- Breakdown of complaints by category
- Fourth quarter trends in rate of complaints (appeals/grievances) per 1,000 members for all CalOptima programs
- Interventions based on trends, as appropriate

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Definitions

- Appeal: A request by the member for review of any decision to deny, modify or discontinue a covered service

- Grievance: An oral or written expression indicating dissatisfaction with any aspect of a CalOptima program

- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction

- Quality of Care (QOC): Concerns regarding care the member received or feels should have been received

Medi-Cal Complaints
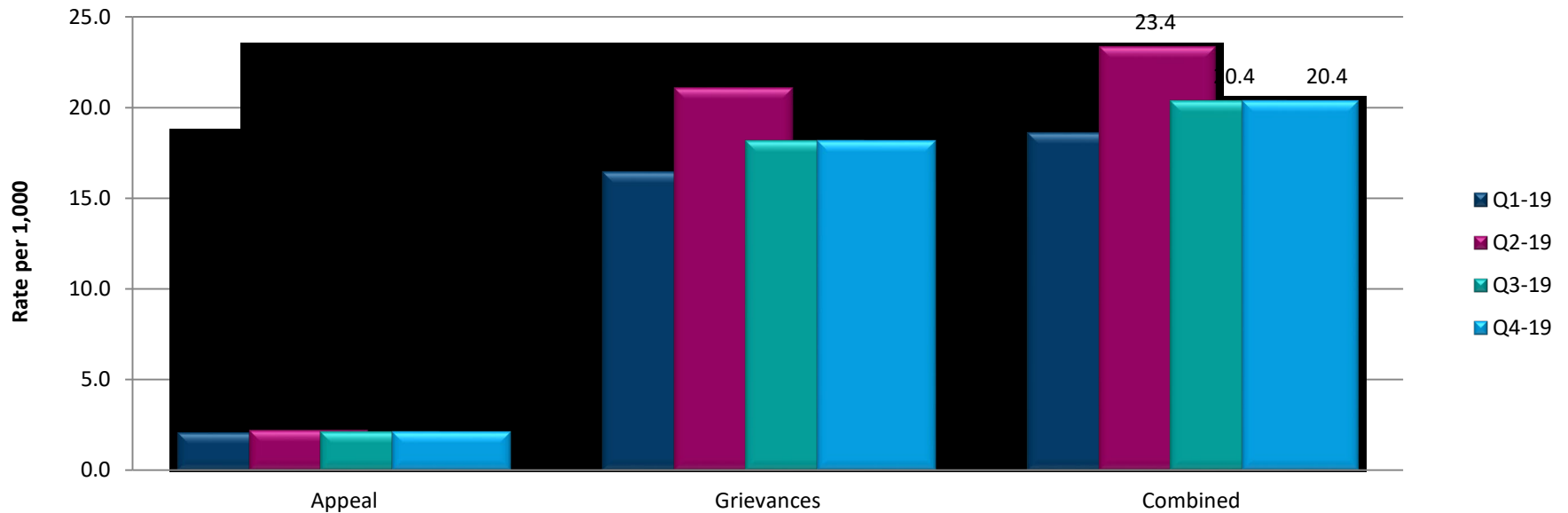
	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2019	3,476	393	3,083	741,963
Q2-2019	4,302	416	3,886	738,880
Q3-2019	3,744	398	3,346	732,115
Q4-2019	3,766	402	3,364	732,116

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Medi-Cal Grievances by Category

- Top grievance types
  - ➢ Delays in service
  - ➢ Question treatment
  - ➢ Non-medical transportation
  - ➢ Provider/staff services
  - ➢ Member billing

Pie chart: Quality of Service 72%, Quality Care 10%, Access 9%, Billing 9%, Practitioner Office <1%

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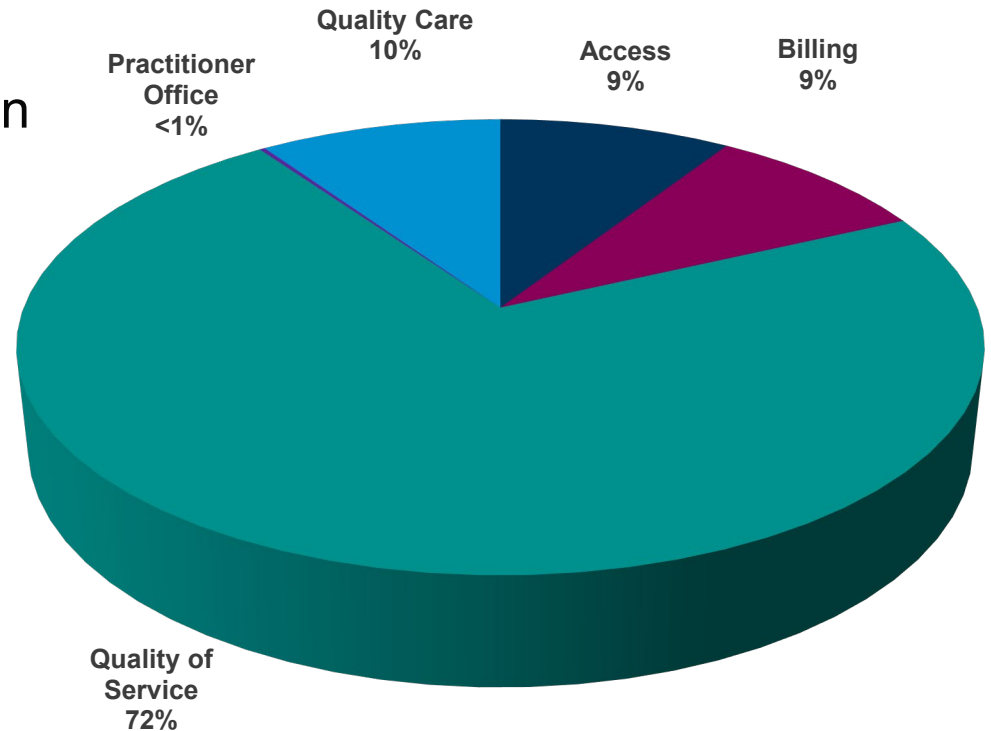
Medi-Cal Member Grievances Quarterly Rate/1,000

	AltaMed (42,926)	AMVI (21,408)	Arta (59,836)	CHA (143,362)	Family Choice (43,996)	Heritage (6,629)	Kaiser (44,032)	Monarch (77,833)	Noble (20,380)	Prospect (33,567)	Talbert (23,691)	UCMG (33,100)	*CCN (80,384)	COD (100,973)	CO Prog (732,116)	CO Pharm (688,084)	MLTSS (688,084)	Behavioral Health (732,116)	VSP (688,084)	Veyo, LLC (116,241)
Q1-19 (3083)	1.19	1.27	2.54	0.66	1.24	4.04	4.19	3.38	1.35	2.97	2.63	1.08	10.02	2.86	0.12	0.20	0.00	0.23	0.02	7.96
Q2-19 (3886)	2.97	1.83	3.02	1.23	1.97	6.64	3.99	4.65	1.94	4.24	4.02	2.21	14.24	2.44	0.20	0.23	0.00	0.24	0.02	5.78
Q3-19 (3346)	2.15	1.15	3.44	1.07	1.72	6.73	3.79	4.41	2.39	3.72	3.26	2.27	12.34	1.84	0.16	0.17	0.01	0.21	0.02	3.47
Q4-19 (3364)	2.45	1.63	3.09	1.05	1.45	5.58	3.66	4.34	2.26	3.66	4.26	1.72	12.54	2.10	0.10	0.10	0.00	0.29	0.03	3.16

Medi-Cal Summary

- Access related grievances have decreased by 5% since Q3, 2019 and 26% since Q2, 2019. GARS continues to work with the QI department to address appointment availability issues.

- Billing grievances increased by 18% due to out-of-area/ out-of-state services.

- Non-medical transportation grievances increased by 9% with an increase of 19% utilization.

OneCare Connect Complaints
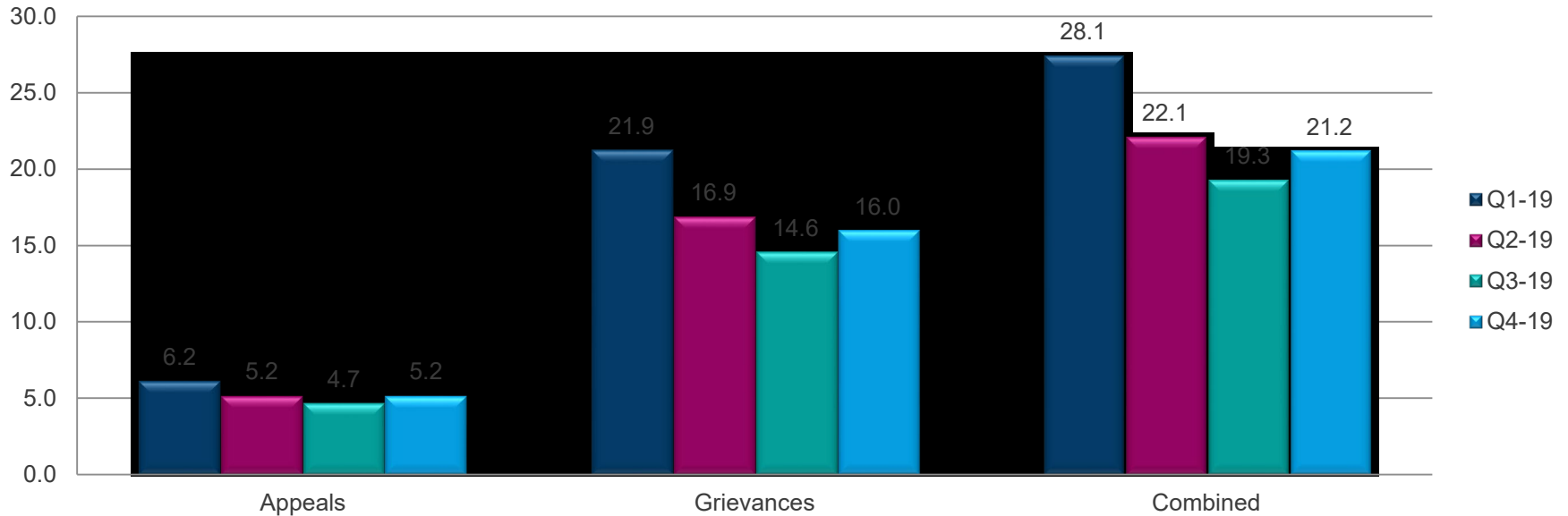
	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2019	402	88	314	14,293
Q2-2019	314	74	240	14,207
Q3-2019	275	67	208	14,205
Q4-2019	302	74	228	14,252

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OneCare Connect Grievances by Category

- Top grievance types
  - ➤ Non-medical transportation (NMT) services
  - ➤ Provider services
  - ➤ Question treatment

Billing 1%
Practitioner Office Site 1%
Access 3%
Quality of Care 5%
Quality of Service 90%

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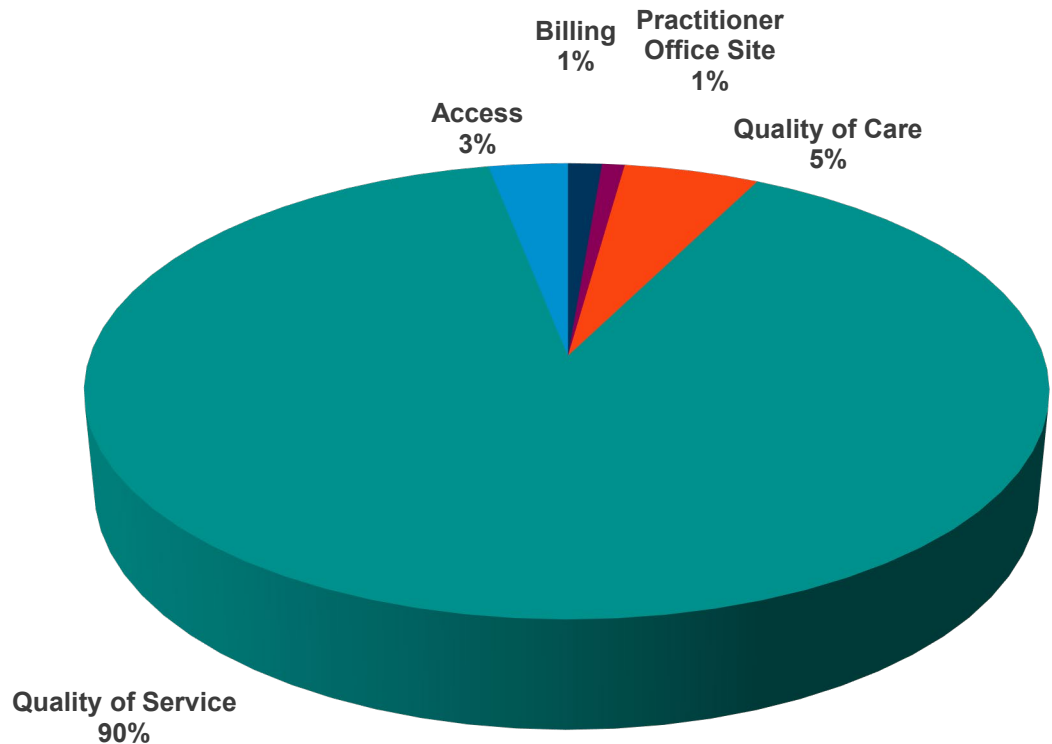
OneCare Connect Member Grievances Quarterly Rate/1,000

Rate per 1,000

	Alta Med Health (500)	AMVI Care (432)	Arta (582)	Family Choice (1,799)	Heritage (199)	Monarch (4,567)	Noble (419)	Prospect (2,318)	Talbert (1,072)	UCMG (541)	CCN (1,825)	OCC Prog (14,252)	OCC Pharmacy (14,252)	MLTSS (14,252)	Behavioral Health (14,252)	Liberty Dental (14,252)	Silver and Fit (14,252)	VSP (14,252)	Veyo (20,975)
Q1-19 (314)	7.5	0.0	3.5	1.7	0.0	7.9	2.3	5.3	4.8	5.9	7.8	0.9	0.9	0.0	0.3	0.3	0.0	0.1	12.2
Q2-19 (240)	3.7	0.0	5.3	0.6	5.0	6.5	0.0	5.9	3.8	0.0	7.1	0.7	0.3	0.0	0.7	0.1	0.0	0.1	8.4
Q3-19 (208)	9.4	0.0	3.5	1.1	5.0	5.2	2.3	7.2	8.6	0.0	9.2	0.7	0.8	0.0	0.3	0.0	0.0	0.1	5.1
Q4-19 (228)	0.0	0.0	3.4	1.7	0.0	8.8	2.4	6.9	1.9	1.8	14.8	0.6	0.5	0.0	0.2	0.0	0.0	0.3	8.0

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OneCare Complaints

	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2019	23	11	12	1,468
Q2-2019	17	5	12	1,514
Q3-2019	18	7	11	1,546
Q4-2019	6	2	4	1,509

OneCare Member Grievances
Quarterly Rate/1,000

	Alta Med Health (66)	AMVI/ Prospect (264)	Arta Western (119)	Family Choice (86)	Monarch (744)	Noble (31)	Talbert (146)	UCMG (53)	OC Operations (1,509)	OC Pharm (1,509)	Behavioral Health (1,509)	Liberty Dental (1,509)	VSP (1,509)	Veyo (87)
Q1-19 (12)	0.0	3.5	0.0	11.0	4.3	0.0	0.0	0.0	0.7	0.0	0.0	0.7	0.0	227.3
Q2-19 (12)	0.0	0.0	8.4	0.0	5.6	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.0	416.7
Q3-19 (11)	23.4	0.0	0.0	0.0	4.1	0.0	0.0	0.0	0.6	0.0	0.0	0.0	0.0	125.0
Q4-19 (4)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.0	0.0	34.5
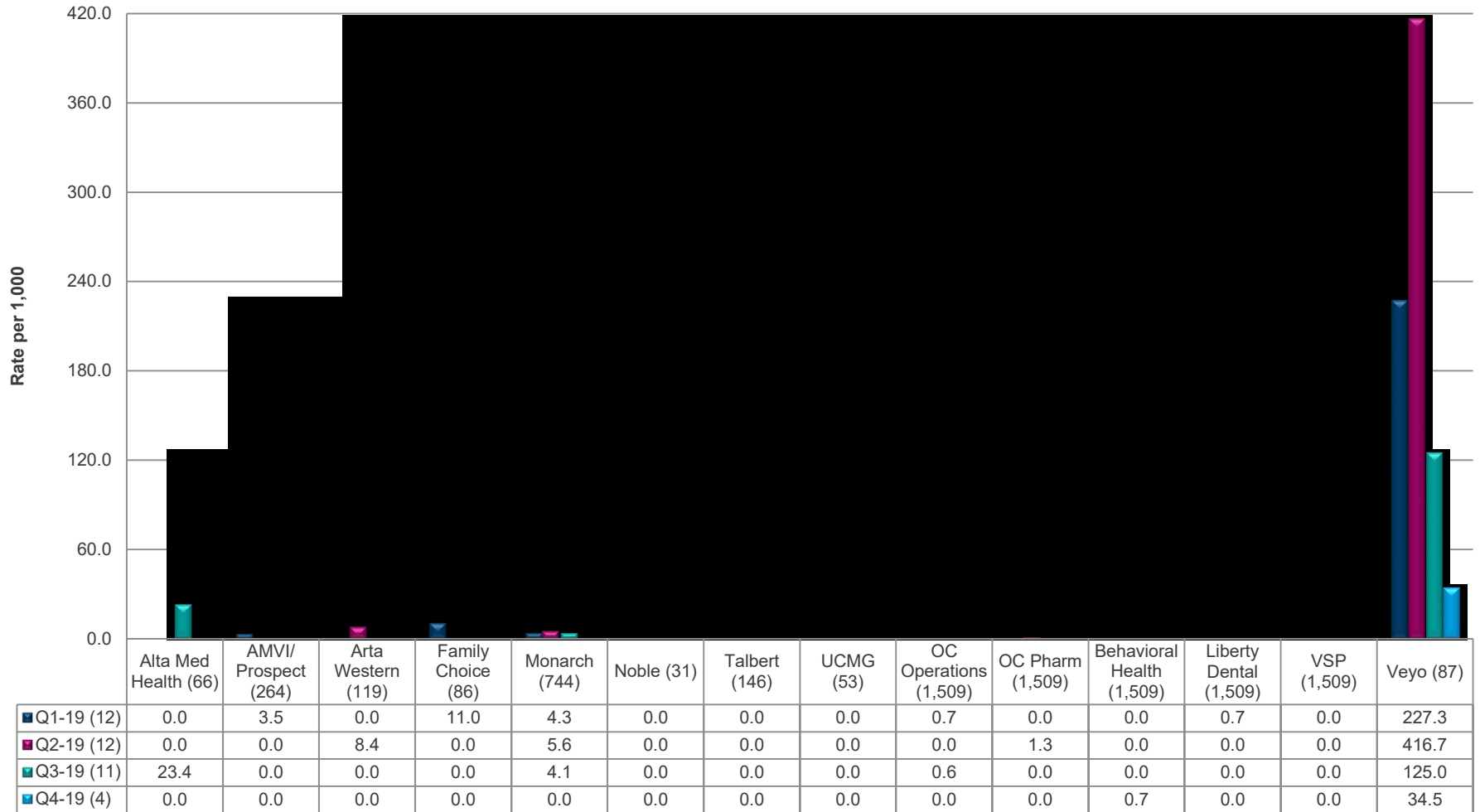
OneCare Summary

- Grievances decreased by 64% from Q3 to Q4

- Grievances were due to the following:

  ➢ Transportation services (no shows)

  ➢ Dissatisfaction with a behavioral health provider

Overall Interventions

- Grievance trends continue review with the Quality Improvement department and shared with Provider Relations leadership for further action.

- Provider Relations staff continue outreach to providers with high grievance count to provide awareness and education.

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

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