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

WEDNESDAY, FEBRUARY 20, 2019
3:00 P.M.

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

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
Paul Yost, M.D., Chair
Ria Berger
Dr. Nikan Khatibi
Alexander Nguyen, M.D.

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Suzanne Turf

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

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 January 17, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
2. Receive and File the CalOptima 2018 Quality Improvement Program Evaluation

3. Consider Recommending Board of Directors' Approval of the CalOptima 2019 Quality Improvement (QI) Program and 2019 QI Work Plan

4. Receive and File the CalOptima 2018 Utilization Management Program Evaluation

5. Consider Recommending Board of Directors' Approval of the 2019 CalOptima Utilization Management Program

6. Receive and File the 2018 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance Performance Improvement Plan Annual Evaluation

7. Consider Recommending Board of Directors' Approval of the 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance Performance Improvement Plan

8. Consider Recommending that the Board of Directors Extend and Authorize Allocations/Reallocations of Spending Rate Year 2010–11 Intergovernmental Transfer (IGT 1) Funds

9. Consider Recommending Board of Directors' Approval of Modifications of CalOptima Policies and Procedures Related to Grievances and Appeals, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule), and Annual Policy Review

10. Consider Recommending Board of Directors' Approval of Policy GG.1657, the Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting Policy

INFORMATION ITEMS
11. Depression Screening Initiative Update

12. Intergovernmental Transfer (IGT) Funding Update

13. Telehealth Strategy

14. Quarterly Reports to the Board of Directors' Quality Assurance Committee
    a. Quality Improvement Committee Update
    b. Member Trend Report Update

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

January 17, 2019

CALL TO ORDER
Chair Paul Yost called the meeting to order at 4:09 p.m. Director Nguyen led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger (at 4:17 p.m.), Dr. Nikan Khatibi, Alexander Nguyen M.D.

Members Absent: All Members present

Others Present: Michael Schrader, Chief Executive Officer; Betsy Ha, Executive Director, Quality Analytics; Diana Hoffman, Deputy Chief Counsel; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the September 12, 2018 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

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

REPORTS

2. Consider Recommending Board of Directors' Approval of CalOptima Population Health Management Strategy for 2019

Betsy Ha, Executive Director, Quality Analytics, presented the action to recommend Board of Directors' approval of the CalOptima Population Health Management (PHM) Strategy for 2019. The National Committee for Quality Assurance (NCQA) created a PHM standard set effective July 1, 2018. The recommended PHM Strategy aims to ensure the care and services provided to CalOptima members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span. As proposed, the year one approach of

the CalOptima PHM Strategy is to align current and new programs to the new PHM framework, and address four focus areas: keeping members healthy, managing members with emerging risk, patient safety or outcomes across all settings, and managing multiple chronic conditions. An overview of the PHM conceptual framework, new standards, proposed PHM strategy, and the timeline and accomplishments to date were provided for Committee discussion.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima Population Health Management strategy for 2019. (Motion carried 4-0-0)***

3. Consider Recommending Board of Directors' Approval of an Amendment to the Board-Approved Action for Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect Lines of Business

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the amendment to the Board-approved Fiscal Year (FY) 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect, so that "continuous enrollment" is assessed at the health plan level instead of at the health network level. (Motion carried 4-0-0)***

4. Consider Recommending Board of Directors' Approval of the Proposed Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019) for Medi-Cal and OneCare Connect Lines of Business

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors' approval of the Fiscal Year 2020 (Measurement Year 2019) Pay for Value Program for Medi-Cal and OneCare Connect, which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable. (Motion carried 4-0-0)***

INFORMATION ITEMS

5. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, provided an overview of the activities at the PMAC meetings held on September 17, 2018 and December 17, 2018.

6. Longitudinal Retrospective Quality Improvement Evaluation

Ms. Ha reported on a tool developed to review longitudinal HEDIS Access and Availability and Member Experience results and establish HEDIS metrics to drive the 2019 Quality Improvement Workplan. Kelly Rex-Kimmet, Quality Analytics Director, provided a demonstration of the tool, Tableau, for Committee review and feedback.

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7. Provider Coaching Pilot Update

Ms. Rex-Kimmet provided an update on the progress of the Provider Coaching Pilot. CalOptima contracted with a health care consultant, SullivanLuallin Group, to implement the pilot with the goals to reduce grievances and potential quality issues and improve customer service performance and member experience and satisfaction. Next steps include continued outreach to health networks and providers on the availability of the coaching and customer service workshops, and to evaluate the effectiveness of the training and interventions.

8. Whole-Child Model Clinical Advisory Committee Update

Emily Fonda, M.D., Medical Director, provided an update on the activities at the Whole-Child Model Clinical Advisory Committee meetings held on January 15, 2019. The Committee received an overview of health network adequacy, the development of quality measures, and a review of the recent Department of Health Care Services (DHCS) All Plan Letter that includes a high-risk infant follow up program that helps identify infants who might develop California Childrens Services (CCS)-eligible conditions after discharge from a neo-natal intensive care unit.

9. Improve Access to Annual Eye Exam for Medi-Cal Members with Diabetes

Ms. Ha provided a brief update on a proposed amendment to CalOptima's contract with Vision Services Plan (VSP) to modify the covered benefit for routine eye exams from one routine exam every 24 months to one annual eye exam every 12 months for Medi-Cal members diagnosed with diabetes. The proposed amendment aligns with the DHCS Medi-Cal and American Diabetes Association approved clinical guidelines. A recommendation to amend the VSP contract will be presented at the February 7, 2019 Board meeting for consideration.

10. Quarterly Reports to the Quality Assurance Committee

The Committee accepted the following reports as presented:

a. Quality Improvement Committee Update
b. Member Trend Report

COMMITTEE MEMBER COMMENTS

Director Berger requested additional information on CalOptima's role in the continuity of care for the homeless population. Committee members thanked staff for their work and wished everyone a Happy New Year.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 5:40 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 20, 2019

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2018 Quality Improvement Program Evaluation

Board of Directors' Quality Assurance Committee Meeting

February 20, 2019

Betsy Chang Ha, RN, MS, MBB

Lean Six Sigma Master Black Belt

Executive Director Quality & Population Health Management

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2018 QI Accomplishments

- For the fifth year in a row, CalOptima achieved the distinction of being identified by NCQA as the top rated Medicaid plan in California
- Noted improvement in several clinical HEDIS measures, can be attributed to Pay 4 Value (P4V) revamped in 2017
- Implemented provider and office staff coaching program to improve Member Experience at physician offices, included health networks
- Redesigned and implemented childhood obesity and perinatal care programs
- In-house administration of the Medi-Cal Behavioral Health mild to moderate benefit including Applied Behavior Analysis

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2019 QI Workplan Focus Measures

Based on longitudinal study conducted on HEDIS measures over the last five years, the following have been identified as key measures that will be tracked and monitored in 2019 QI Work Plan:

- Adult Health – Mental
  - AMM (Antidepressant Medication Management) for Acute and Continuation phases
- Adult Health – Physical
  - Breast Cancer Screening (BCS)
  - Cervical Cancer Screening (CCS)
  - Access to Preventive/Ambulatory Health Services (AAP)

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2019 QI Workplan Focus Measures

- Child/Adolescent Health
  - Depression Screenings Initiative
  - Attention Deficit Disorder (ADD)
  - Five Child and Adolescent Well-Care measures
  - Children with Pharyngitis (CWP)

- Maternal Child Health
  - Prenatal and Postpartum Care (PPC)

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2019 QI Workplan Focus Measures (cont.)

- Chronic Conditions
  - Asthma Medication Ratio (Asthma – AMR)
  - Comprehensive Diabetes Care (Diabetes – CDC)
    - HbA1C testing, Poor Control >9%, Control <8%
    - Eye Exam
    - Nephropathy
    - Blood Pressure
  - Heart Health — CCIP/QIP/PIP

- Coordination of Care
  - Follow-up after hospitalization for mental illness for OCC
  - ED utilization for BH services
  - 30 Day Readmissions
  - ICT Team Participation

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2019 QI Workplan Focus Measures (cont.)

- Safety of Clinical Care
  - Review and follow-up of potential quality of care issues
  - Facility Site Review and Physical Accessibility Review Surveys
  - Credentialing of providers
  - Opioid Monitoring Program — Be Safe pilot program
- Access & Availability
  - Timely Access Survey (appointment availability)
    - Primary care and specialty care
    - Includes BH
  - Network Adequacy (access to network)
    - Time and distance standards
    - Network certification

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QI Opportunities for 2019

- Maintain “Commendable” accreditation status and top Medicaid health plan rating through achievement of high HEDIS/CAHPS scores (50th percentile or higher on all measures)
- Implement Population Health Management strategy
- Improve performance on Clinical HEDIS metrics through the continuation of CalOptima Days, and other targeted initiatives which close gaps in care
- Improve member experience through expansion of provider coaching and customer service training, to include all health network providers and office staff on the PQI list

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QI Opportunities for 2019

- Increase member experience related to Network Adequacy/Access and Availability (AA) and meet network adequacy standards established for the Whole-Child Model (WCM) program
- Implement California Children's Services WCM, transition to CalOptima effective 7/1/2019
- Continue partnership with the Coalition of Orange County Community Health Centers to monitor community clinics performance on key quality metrics and assist them with developing strategies for closing gaps in care

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2018

QUALITY IMPROVEMENT EVALUATION

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2018 QUALITY IMPROVEMENT EVALUATION

SIGNATURE PAGE

Quality Improvement Committee Chair:

David Ramirez, M.D.
Chief Medical Officer

Date

Board of Directors' Quality Assurance Committee Chair:

Paul Yost, M.D.

Date

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2018 Quality Improvement Evaluation of Overall Program Effectiveness

Executive Summary

Activities in the 2018 Quality Improvement (QI) Program and associated Work Plan activities focused on refining the structure and process of care delivery, with the emphasis on member centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision and Strategic Initiatives of the Board.

The 2018 Annual QI Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities undertaken during the first three quarters of the calendar year 2018 to improve the health care and service available to members of CalOptima. The final 2018 QI Work Plan with the full calendar year results will be presented as a separate document in Q1 2019 to the QI Committee. The 2018 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2018 QI Program and its Work Plan.

Program Structure

In 2018, CalOptima sustained the development of its QI Program and infrastructure that included:

- A written Evaluation of the 2017 QI Program reviewed and approved by the QI Committee (QIC) on January 23, 2018, and the Board of Director's Quality Assurance Committee (QAC) on February 20, 2018.

- A written QI Program Description for 2018 included structure, scope, and process which was reviewed and approved by the QIC on January 23, 2018 and the Board of Director's Quality Assurance Committee (QAC) on February 20, 2018.

- A written Work Plan for 2018 that included clinical, patient safety and service monitors to evaluate quality activities, and that were reviewed and approved by the QIC on January 23, 2018 and the Board of Director's QAC on February 20, 2018.
    - The CalOptima Medical Directors provided direction and supervision of QI activities at the direction of the Chief Medical Officer (CMO). Overall oversight of the QI Program was provided by the Board of Directors.

2018 QI Program Goals Accomplishments

In 2018, CalOptima sustained the considerable and major steps in the development of its QI infrastructure, which included the achievement of National Committee for Quality Assurance (NCQA) Commendable Status. The QI Program incorporates continuous QI methodology of

Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies):

- It was organized to identify and analyze significant opportunities for improvement in care and service.
    - Accomplished as evidenced by the following summaries by population.
- It fostered the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
    - Accomplished as evidenced by multidisciplinary committees, participation by practicing network providers, company-wide subcommittees and collaboration with delegated entities.
- It focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.
    - Accomplished as evidenced by the following summaries by population,
- Maintained a functional and viable QIC structure to oversee all lines of business.
- Developed a new format for the 2018 QI Work Plan.
    - This format allowed the organization to evaluate and track the effectiveness of the QI Program throughout the year.
    - Quarterly status updates to subcommittees were documented, tracked, and presented in a dashboard to the QIC.
- Completed activities in preparation for the 2018 NCQA accreditation survey that took place in July of 2018.

QI goals and objectives are to monitor, evaluate and improve:

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
    - Accomplished as evidenced by Healthcare Effectiveness Data and Information Set (HEDIS) results reported in 2018.
    - Accomplished as evidenced by follow up with potential quality issues with practitioners and facilities, monitoring of member grievances and complaints, and review of delegated entities review processes.
    - Collaboration with the Compliance department for identification of potential quality issues that may have involved fraud, waste, abuse, confidentiality, security, etc.
- The important clinical and service issues facing the Medi-Cal population relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care.
    - Aligned with Clinical Practice Guidelines.
    - Includes Medical and Behavioral Health population management activities.
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities.
    - Accomplished as evidenced by the strong increase in interdisciplinary care team meetings, which include primary care, specialty and behavioral health practitioners.

- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population.
    - Accomplished as evidenced by the access and availability studies and summary of activities from the Access and Availability Subcommittee.
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
    - Accomplished as evidenced by a solid credentialing and peer review process.
- Member and provider satisfaction, including the timely resolution of complaints and grievances.
    - Accomplished as evidenced by Member Experience Surveys and Reports, the Primary Care Provider (PCP) Satisfaction Survey and the summary of the Grievance & Appeals Resolution Services (GARS) activities.
- Risk prevention and risk management processes.
    - Accomplished as evidenced by sound Potential Quality Issue (PQI) process to identify and address high-risk practitioners.
- Compliance with regulatory agencies and accreditation standards.
    - Accomplished through participation in mock and regulatory audits, and required Performance Improvement Projects (PIP) and QI Projects (QIP).
- Annual review and acceptance of the Utilization Management (UM) Program Description and UM Work Plan.
    - Accomplished as evidenced by the acceptance of the UM Program Description and Work Plan at QIC on January 23, 2018, and the QAC on February 20, 2018.
- The effectiveness and efficiency of internal operations and operations associated with functions delegated to the contracted medical groups.
    - Accomplished as evidenced by progress reports by individual departments and quarterly delegation reports.
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values.
    - Accomplished as evidenced by achievements in cross-departmental activities to improve member experience, expansion of the pay-for-value program, and further focus on the opioid epidemic.
- Compliance with Clinical Practice Guidelines (CPG) and evidence-based medicine.
    - Accomplished as evidenced by the annual review and acceptance of updated CPGs for medical and behavioral guidelines.
- Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
    - Accomplished as evidenced by Audit & Oversight (A&O) department quarterly reports of functions delegated to the Health Networks (HNs) or conducted by internal departments.
- Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDO) to assure that steps are taken to resolve and prevent recurrences.

- Accomplished as evidenced by QI reviews of Facility Site Reviews.
- Accomplished by ongoing monitoring and implementation of pharmacy initiatives including over/under utilization and specialty drug utilization.
- Accomplished by Community-Based Adult Services (CBAS), and Skilled Nursing Facility (SNF) Long-Term Care (LTC), ongoing monitoring and reporting of Critical Incidents.

QI PROGRAM RESOURCES AND COMMITTEE STRUCTURE

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Ongoing data analysis across multiple areas provides the basis for identifying over/under utilization of services. Our approach also uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

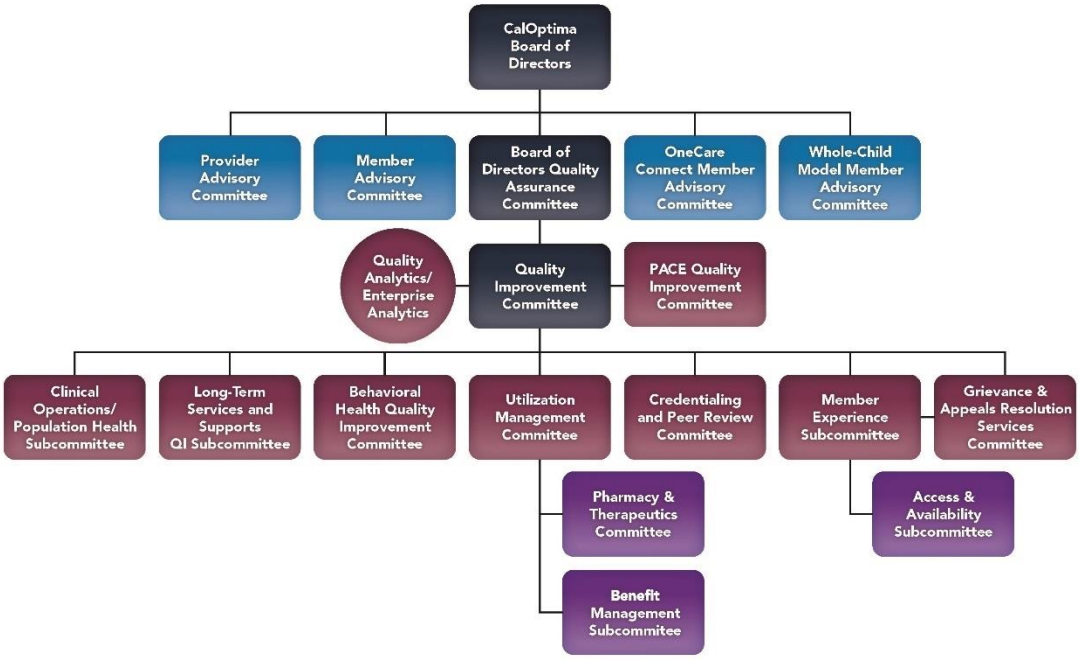
The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's QAC. Table 1 shows the frequency of the QIC and QAC meetings during 2018.

Table 1:

Committee Meeting Dates				
QAC (Quarterly)	2/20/2018	5/16/2018	9/12/2018	~~11/21/2018~~ (Postponed to 1/17/19)
QIC (Monthly or at least 8 times/year)	01/23/2018 02/13/2018 03/13/2018	04/10/2018 05/08/2018 06/12/2018	07/17/2018 08/14/2018 09/11/2018	10/09/2018 11/13/2018 12/11/2018

Committee and Subcommittee Reports
Six committees and subcommittees support CalOptima's QI Program and report to QIC at least quarterly.

2018 Committee Organization Structure — Diagram



As seen in the above reporting structure diagram, these committees are:

1. **Credentialing Peer Review Committee (CPRC)**
   The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC, chaired by the Deputy CMO, reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all CalOptima practitioners. In addition, the CPRC reviews Potential Quality Issue cases that impact the quality of care of CalOptima members. In 2018, CPRC met 11 times.

2. **Behavioral Health Quality Improvement Committee (BHQIC)**
   The Behavioral Health Integration (BHI) department manages the BHQI committee, which reports up to the QIC. The 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. The BHQI is chaired by the Medical Director of BHI and comprised of members internal and external to CalOptima including delegated networks, 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 2018 for additional work and analysis on the 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.

3. **Utilization Management Committee (UMC)**
   The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC, chaired by the UM Medical Director, monitors the utilization of health care services by CalOptima Direct and Medi-Cal overall through the delegated HNs to identify areas of under or over utilization that may adversely impact member care. In 2018, the UMC met quarterly; it monitored medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. The UMC also reviewed and approved the 2018 UM Program and Work Plan on 03/22/18.

4. **Pharmacy & Therapeutics (P&T) Subcommittee**
   P&T subcommittee reports to the UMC, and is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. In 2018, the P&T met quarterly and addressed key pharmacy issues facing our providers and members.

5. **Member Experience (MEMX) Subcommittee**
   The MEMX focuses on the issues and factors that influence the member's experience with the health plan. The MEMX subcommittee is designed to assess the annual results of CalOptima's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, monitor the provider network including access and availability (CCN and HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members experience with the health plan. In 2018 MEMX subcommittee met bi-monthly to review survey results, and develop action plans to address member experience concerns.

6. **Grievance & Appeals Resolution Services (GARS) Subcommittee**
   The GARS subcommittee reports up to the MEMX and met quarterly. GARS protects the rights of our members, and to promote the provision of quality health care services, and enforces that the policies and procedures of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. Quarterly, the GARS subcommittee reviews the member trend report, which includes rate of complaints (appeals/grievances), a breakdown of complaint by type and interventions based on trends.

7. **Long-Term Services and Supports QI Subcommittee (LTSS QISC)**
   The LTSS QISC met on a quarterly basis in 2018, and addressed key components of regulatory, safety, quality and clinical initiatives. The LTSS/Case Management Medical Director chairs the LTSS QISC meetings, whose members also include administrators and clinical leaders from the following groups: CBAS providers, Orange County Social Services Agency (OC SSA) In-Home Supportive Services (IHSS), OC Public Authority (PA) IHSS, nursing facilities (NF), Multipurpose Senior Services Program (MSSP), delegated HNs and other CalOptima clinical and operational staff. In 2018, LTSS reviewed progress on the LTSS PIP, IHSS and CBAS staffing and utilization measures, and NF quality measures.

8. **Clinical Operations/Population Health Subcommittee (COPHS)**
   The Clinical Operations/Population Health subcommittee, also known as Medical Affairs, exists to oversee, guide and ensure the integration and coordination of functions across the continuum of care, including but not limited to population health, disease management, care management, complex case management, UM, LTC, pharmacy, and behavioral health services. This subcommittee monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care. These programs are reviewed at monthly meetings and updated through the QI Work Plan updates which is reflected in the QI Work Plan dashboard quarterly.

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

Each committee reported quarterly to QIC; minutes were submitted and approved. Presentations from each committee focused on the QI or UM Work Plans and included reports on progress-to-date, issues and/or barriers identified collaboration across functional areas, and any operational concerns.

The QI committee structure allowed for adequate program resources to be allocated in each of the subcommittees, as evidenced by Medical Director and external practitioner involvement as well as CalOptima's senior leadership involvement at various subcommittees and at the QIC. This reporting structure was new in 2018, and provided a sound infrastructure for tracking quality program results as evidenced by the QI Work Plan updates and dashboard. Towards the end of 2018, it was determined that the Clinical Operations Population Health functioned more effectively as a workgroup versus a subcommittee, and continued to address clinical operational topics. Hence, COPHS was removed in 2019's program structure diagram. Key business functions continued to meet through 2018 and addressed relevant QI Work Plan updates through

the quarterly dashboard, however did not continue to report as a subcommittee to QIC for Q3 and Q4. In 2019 clinical measures will still be reported to QIC via the QI Work Plan.

In 2018, the Whole-Child Model Clinical Advisory Committee was created. A charter was developed and members were nominated. The first meeting took place in September 2018, however with the delay of the Whole-Child Model program until July, 2019, the next meeting will take place in the first quarter of 2019. This committee will provide quarterly updates to the QIC in 2019.

SUMMARY EVALUATION AND OPPORTUNITIES FOR IMPROVEMENT IN 2019

For CalOptima, 2018 was a year of quality achievement. For the fifth year in a row, CalOptima was named the top rated Medicaid plan in California according to the NCQA's Medicaid Health Insurance Plan Ratings 2018–2019. Additionally, CalOptima maintained NCQA "Commendable" health plan accreditation status. Both achievements reflect CalOptima's dedication to Quality Care for our members in accordance with our mission statement, vision and values.

In 2018, we noted improvement in several clinical HEDIS measures. Some of this improvement can be attributed to our Pay 4 Value (P4V) program which was significantly revamped in 2017. Measures incentivized through our P4V program did perform better than other measures that were not incentivized.

Eight quality initiatives were implemented in 2018 to improve performance in breast and cervical cancer screenings, postpartum care and diabetes A1C testing and control. Both member and provider incentives were newly implemented to test member and provider response to monetary incentives. Response to the member and provider incentives reflects a low response rate through November, 2018. Final results and analysis of impact will be available after Q1 2019, once data collection is considered complete. In addition to internally developed quality initiatives, six regulatory required and highly prescribed PIPs and QIPs were initiated. One Chronic Care Improvement project (CCIP) concluded. Due to the highly prescribed methodology outlined by the regulators, it was challenging to leverage staff resources across the spectrum of clinical measures targeted for improvement.

Improving the "Member Experience" continued to be a major focus in 2018. CalOptima's member experience scores lag behind other county organized health system (COHS) model Medicaid plans and California lags behind the rest of the nation in member experience scores. (our Medicaid reimbursement rate lags behind the rest of the country as well). Member pain points such as timely access to PCP's and specialists, referrals for coordination of care, member communications, customer service and potential quality indicators (PQIs) were reviewed and evaluated for actions needed. A request for proposal (RFP) was issued in 2018 for targeted provider and office staff coaching services. A contract award was made. The provider and office staff coaching program was implemented in 2018 and is expected to have a material impact on individual provider member experience scores which will be reflected in improved member experience scores for CalOptima.

Member programs for childhood obesity such as "Shape your Life" and Perinatal Care were redesigned and expanded and implemented in 2018.

Behavioral health implemented a major change by bringing administration of the Medicaid network for mild to moderate services in-house on January 1, 2018. This was a major lift for the behavioral health team as well as for other departments that supported the transition.

QI opportunities in 2019 include the following:

- Continue to maintain demonstration of quality of care excellence via achievement of NCQA accreditation and top Medicaid health plan rating.
- Implement Population Health Management strategy to align with accreditation requirements.
- Improve performance on Clinical HEDIS metrics through the continuation of CalOptima Days for high volume provider offices.
- Improve performance on Behavioral Health HEDIS metrics.
- Improve analysis of effectiveness/return on investment of internally developed Quality Initiatives and P4V Program.
- Improve member experience through expansion of provider coaching training, and customer service training, to include all HN providers and office staff on the PQI list
- Increase member experience related to Network Adequacy/Access and Availability (AA) in order to improve performance on AA standards and meet network adequacy standards established for the Whole-Child Model program. Implement "Timely Access Survey" with mystery shopper component and implement more prescribed corrective action plans for HNs identified as not meeting AA standards.
- Continue partnership with the Coalition of Orange County Community Health Centers to monitor community clinics performance on key quality metrics and assist them with developing strategies for closing gaps in care

EVALUATION OF QI PROGRAMS

ADULT HEALTH — MENTAL HEALTH

INTRODUCTION:

Changes to managed care and the addition of mild to moderate benefits for behavioral health care services for Medi-Cal members has provided CalOptima the opportunity to develop quality programs to support integrated care. Integrated care is the practice of coordinating behavioral

health, substance abuse, and general health care services for better member outcomes. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "mild to moderate behavioral health problems are common in primary care settings" and "many people with behavioral health problems have medical health problems concurrently (2018)." Working towards an integrated model helps ensure better treatment for member with complex health care needs.

QI ACTIVITIES:

Managing Care for Adult Members Diagnosed With Major Depression
It is documented that "an estimated 16 million American adults — almost 7% of the population — had at least one major depressive episode in the past year (NAMI, 2018)." CalOptima recognizes the impact of depression on its members and that diagnosis and treatment at the earliest opportunity can help reduce the impact on day-to-day functioning. Further, we want to encourage members to adhere to treatment to maximize the therapeutic benefits. CalOptima has developed several strategies to monitor the use of services provided for treatment of depression. One such strategy is looking at claims submitted with a depression diagnosis and filtered through our HEDIS program triggering a positive identification for the Antidepressant Medication Management (AMM) HEDIS measure.

TRENDING OF MEASURES / RESULTS:

The BHI department monitors the follow up care for members with a diagnosis of Major Depressive Disorder who are prescribed an antidepressant medication for treatment. This quality initiative is part of the set of HEDIS measures that CalOptima monitors, and important for the behavioral health team to track and trend given the higher incidence of this diagnosis over any other. It is important to understand how well we are doing to provide service to members and where we can make improvements. The rate is calculated separately for members with Medi-Cal and for members with OneCare (OC) and OneCare Connect (OCC).

Medi-Cal — ACUTE PHASE TREATMENT: ANTIDEPRESSANT MEDICATION MANAGEMENT			
HEDIS Reporting Year	NCQA 50TH PERCENTILE	GOAL	FINAL
2018	51.89 %	56.94 (P75)	56.69%
2017	53.38 %	59.52 (P75)	55.28 %

Medi-Cal — CONTINUATION PHASE TREATMENT: ANTIDEPRESSANT MEDICATION MANAGEMENT			
HEDIS Reporting Year	NCQA 50TH PERCENTILE	GOAL	FINAL
2018	36.19 %	41.12 (P75)	41.19 %
2017	38.06 %	43.39 (P75)	40.94 %

For the Medi-Cal population, we have continued to meet the minimum of the 50th percentile rate. There has not been a significant change in the rates. Aside from rates, the intention is to ensure that members are being seen for follow up care when they are prescribed an antidepressant medication for depression. As of November 2018, both AMM metrics are slightly above the prior year's final rate.

OCC — ACUTE PHASE TREATMENT: ANTIDEPRESSANT MEDICATION MANAGEMENT			
HEDIS Reporting Year	NCQA 50TH PERCENTILE	GOAL	FINAL
2018	69.11 %	63.45 %	62.59 %
2017	69.47 %	55.25 (baseline)	60.56 %

OCC — CONTINUATION PHASE TREATMENT: ANTIDEPRESSANT MEDICATION MANAGEMENT			
	NCQA 50TH PERCENTILE	GOAL	FINAL
2018	53.90 %	47.09 %	45.41 %
2017	55.26 %	36.99 (baseline)	43.17 %

For the OC population, the population is low and therefore no longer being reported. Most members have transitioned into OCC unless they do not qualify.

For OCC, we began reporting for HEDIS in 2017. There has been a dip in the rates for this population for the acute phase treatment and for the continuation phase treatment measures. Since the intention of the measure is to ensure members are seen for follow up after prescription of antidepressants, this is an opportunity for improvement. This population is being managed by the Managed Behavioral Health Organization (MBHO) and BHI holds monthly clinical meetings to address this and other topics related to member care. As of November 2018, both AMM metrics for OCC are slightly above the prior year's final rate, however is only at 25th percentile for effective treatment, and below 25th percentile for continuation phase treatment.

In previous years, CalOptima offered additional resources to providers and members to help start and continue the conversation surrounding treatment of major depression. Despite offering those resources, analysis showed that the number of members completing a follow up visit had not improved. One theory for these results that remain consistently level with no improvement over the years is that the lack of direct member intervention may be a key barrier to improvement. Members may start to feel better after their initial appointment and prescription and may not understand the importance of continuation of therapy and continued appointments with their practitioner(s). This is where the work of behavioral health and our network of providers will be essential to helping to change that practice.

NEXT STEPS:

The behavioral health work group meets monthly and takes all suggestions from the BHQI committee members and partners to look at best ways to improve care for members. Through our

local partnership with HNs, we were able to tap into an educational resource for providers. Additionally, the work group has been reviewing best practices on a national level and plans to submit a proposal to the quality committees for approval to develop a provider toolkit specific to behavioral health. The idea behind the toolkit is to provide targeted information that is unique to behavioral health services in one reference material. This will help to educate and assist new and continuing providers with improving the management of behavioral health services. Taking into consideration that providers are required to complete a set number of educational units to renew their license each cycle, an additional intervention we agreed could be useful is to host or partner on local CME events. Routine announcements are sent to the provider network and invitations targeted at learning more about behavioral health diagnosis, symptoms, treatment options and how to refer to behavioral health services through CalOptima are shared with appropriate staff to encourage participation. Each year, behavioral health hosts or partners with local HNs in conducting a series of behavioral health events focused on targeted behavioral health topics. After the most recent events, we did notice an increase in follow up care for members leading us to believe that keeping the information fresh and within reach will help providers and members practice timely management of care.

REFERENCES:

National Institute of Mental Illness, NAMI 2017. Mental Health Conditions: Depression. https://www.nami.org/Learn-More/Mental-Health-Conditions/Depression/Treatment

SAMHSA, 2016. Back to the Basics: What you Need to Know about Primary and Behavioral Health Care Integration. https://www.integration.samhsa.gov/about-us/CIHS_Integration_101_FINAL.pdf

ADULT HEALTH — PHYSICAL HEALTH

INTRODUCTION:

Overall, CalOptima has over 760,000 members in which over half are adults ages 18 years and older. The majority of our adults are in the Medi-Cal program, followed by the OCC program with 14,651 members and OC program with 1,423 members as of November 2018. Providing access to quality health care services and promoting health and wellness to our members is part of CalOptima's mission. This year, CalOptima engaged in several initiatives surrounding adult health. The focused HEDIS measures included women's health preventive care including breast and cervical cancer screening and access to ambulatory/preventive care services.

QI ACTIVITIES: Women's Health

Breast and Cervical Cancer Screening Initiatives

Building upon last year's focus on women's health, CalOptima expanded the breast and cervical cancer member incentives promoting these two preventive screenings. Women's health is an area of focus, particularly in certain ethnic communities such as the Asian and Latino populations, who continue to be disproportionally impacted by these health conditions. Members who completed a breast and/or cervical cancer screening could receive a gift card in the amount of

$15 and $20 respectively. This member incentive program ran from June 1 through December 31, 2018. CalOptima continued to promote breast and cervical cancer screenings through print ads and billboards coordinated by our Communications department. In addition, the member incentive programs were also promoted through our Good Health page on CalOptima's website. We collaborated internally with our Customer Service, Community Relations and Provider Relations departments to expand the outreach. We included a Facet's pop-up messaging campaign in which Customer Service Representatives (CSRs) were prompted to promote our member incentive program whenever a member would call into CalOptima. Much effort was put into continuing the momentum of promoting Women's Health initiatives this year.

Both the breast and cervical cancer screening measures continued to be incentivized in our P4V Programs.

Mobile Mammography Events

This year, CalOptima worked with our Community Relations department to conduct mobile mammography screenings and/or cervical cancer screenings for our CalOptima Community Network (CCN) members. CalOptima also collaborated with our community partners and clinics to offer no-cost mammograms and cervical cancer screenings for the uninsured/underinsured populations through the "Every Woman Counts" program. This was a great opportunity for CalOptima to work with our partners to ensure more women have access to preventive care services. CalOptima conducted three half-day mobile mammography events at the following locations: 1) CalOptima's Satellite office located in Westminster, CA, 2) partnered with a CalOptima Community clinic in Garden Grove, and 3) worked with community partners to provide screenings at a Family Resource Center in Anaheim. In addition, our community partners were able to also provider clinical breast exams for patients at no additional cost. Providers volunteered their time to provide this service to members.

2018 Mobile Mammography Event and Locations

Event	Date	Completed Services	Number of CCN Members
CalOptima Satellite Office (Westminster)	March 10, 2018	19 mammograms	14 CCN members
Nhan Hoa Comprehensive Health Care Clinic (Garden Grove)	August 15, 2018	11 mammograms 11 cervical cancer screenings	22 services for CCN members
Mira Loma Family Resource Center (Anaheim)	November 13, 2018	31 mammograms	16 CCN members

This year, CalOptima contracted with a mobile mammography vendor to conduct mammogram screenings for our CCN members. The events were very well-received by the community. We anticipate continuing our efforts in outreaching to more members and improving access to care.

MEDI-CAL PERFORMANCE IMPROVEMENT PROJECTS (PIP)

Improving Adult's Access to Preventive/Ambulatory Health Services for Medi-Cal Members 45-64 years:
Annually, CalOptima participates in QIP, PIP, and Chronic Care Improvement Projects (CCIP) as directed by California's Department of Health Care Services (DHCS). This year, CalOptima chose to focus on the Access to Preventive/Ambulatory Care (AAP) measure because our overall Adult's Access to Preventive/Ambulatory Health Services (AAP) rate has declined over a four-year period from 2014 82.27% to 2017 67.29%. The rate took a significant decline in performance from 2015 77.76% to 2016 67.16% with the Medicaid expansion. The 2017 rate of 67.92% sits 9.95% below the 25th percentile. Additionally, for HEDIS 2017 the sub-measure's rate for Ages 20-44 59.75% is 13.6% lower than 25th percentile and Ages 45-64 75.69% is 6.8% lower than the 25th percentile benchmark.

While CalOptima data shows the subgroup of 20-44 years has a lower rate than the subgroup of 45-64 years, CalOptima has chosen to focus on the second subgroup due to the following reasons: a) 45-64 years subgroup may benefit more from preventive/ambulatory health visits than their counterpart (20-44 years), and b) have better health outcomes due to accessing a health care provider for needed health care services.

CalOptima will be implementing two interventions for this PIP project. The first is a member incentive program in which members could receive a $25 gift card for completing an annual health visit with their PCP. The second intervention is a provider office staff incentive program. Office staff is incentivized based on improvement from last year's monthly screening average for the AAP measure and staff could receive a $10 gift card for each member above that rate. If testing this intervention proves to be successful, CalOptima will consider expanding this initiative to more offices and/or networks in the future. As part of this intervention, staff are to conduct outreach to members based on registry list provided by CalOptima.

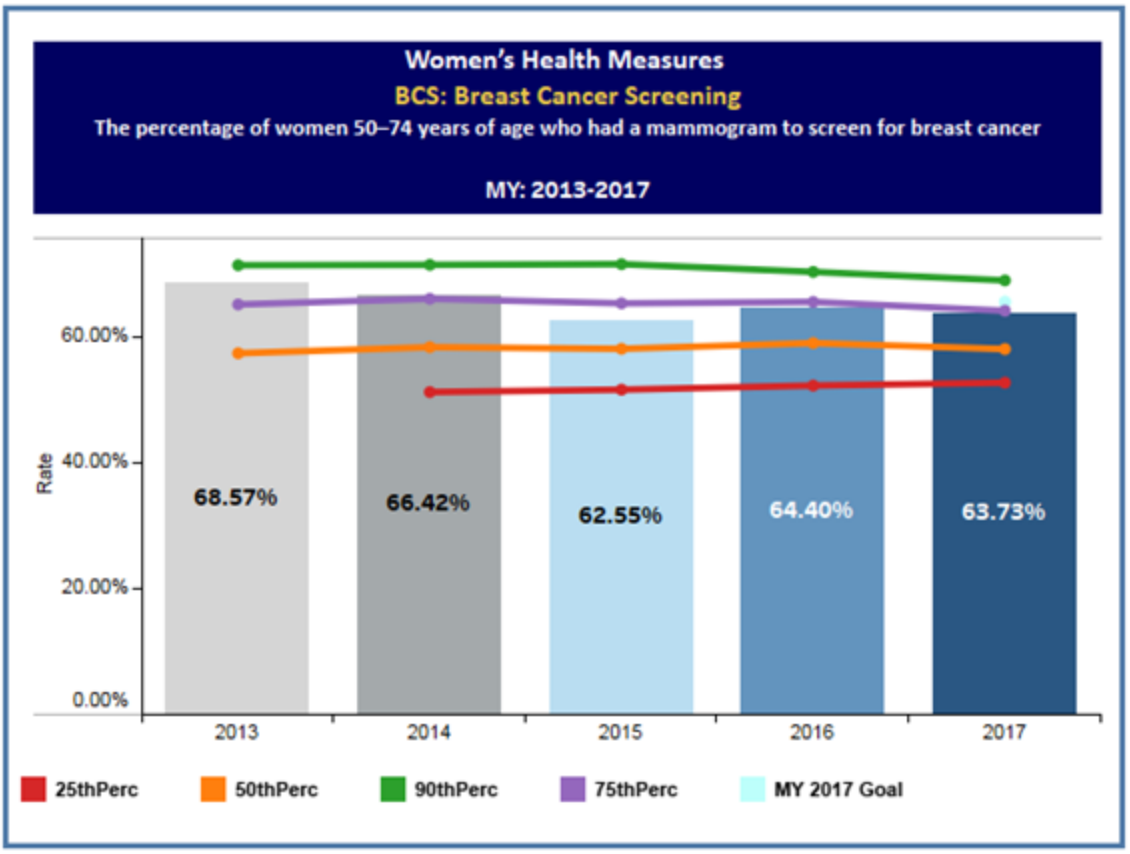
TRENDING OF MEASURES / RESULTS:

Breast Cancer Member Incentives

BREAST CANCER SCREENING INCENTIVE	
Mailing population: N=16,340	Total
Number of forms submitted to CalOptima	540
Number of members approved for incentive	432
Response Rate	3.3%

- Data as of November 30, 2018

Breast Cancer Screening (BCS) Measure



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	52.70%	58.04%	64.12%	68.94%	63.73%	65.52%	-1.79%
2016	52.24%	58.99%	65.52%	70.29%	64.40%	65.30%	-0.90%

The BCS measure remains at the 50th percentile of the NCQA Quality Compass benchmarks. There was a slight decline by 1.79% compared to last year. While there was a slight decline, the change was not statistically significant. Year-to-date (YTD) (as of November 2018), the BCS measure is performing about the same as the year before.

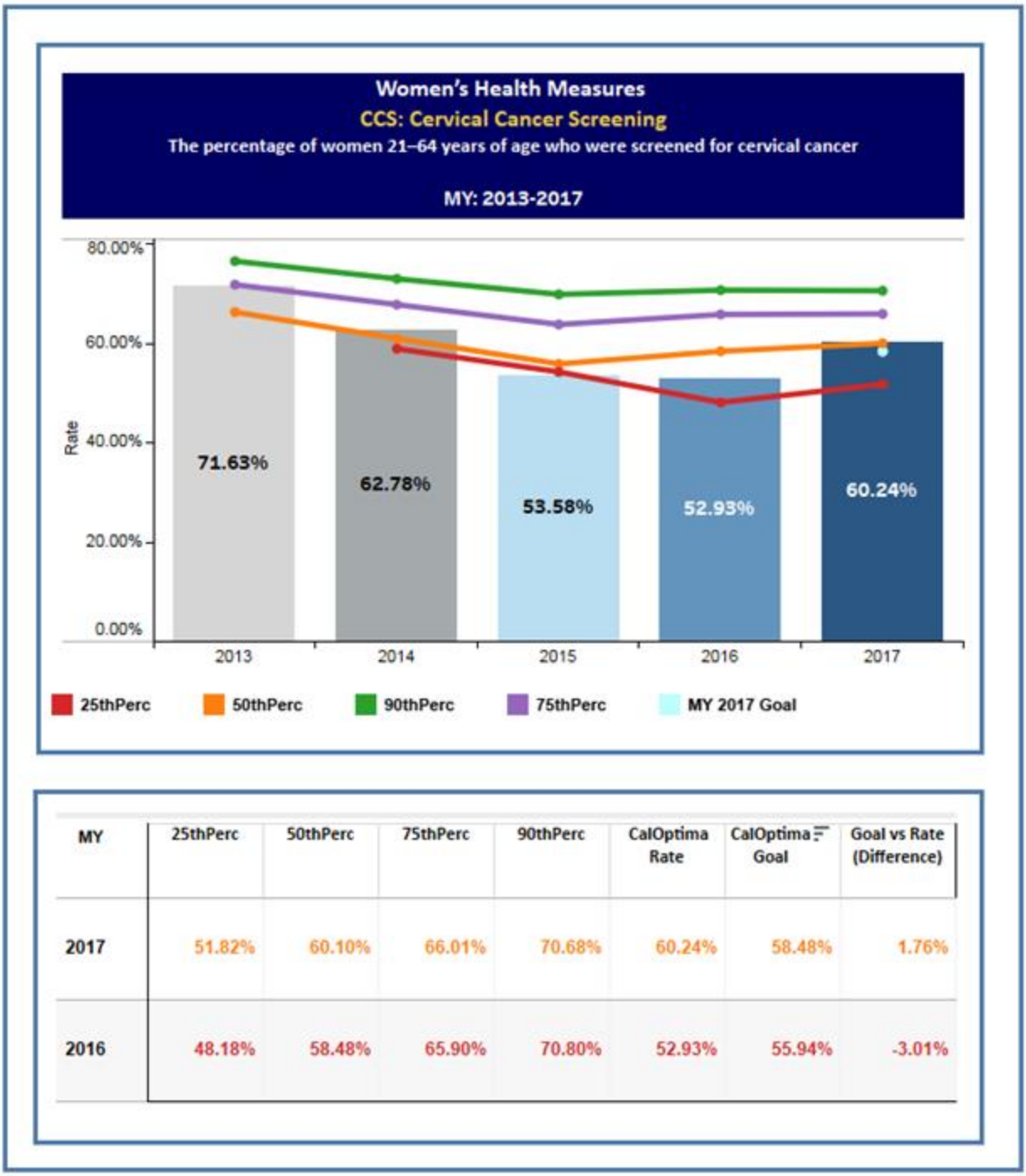
Cervical Cancer Screening (CCS) Member Incentive

CERVICAL CANCER SCREENING INCENTIVE

Mailing population: N=66,675	Total
Number of forms submitted to CalOptima	768
Number of members approved for incentive	574
Response Rate	1.2%

- Data as of November 30, 2018

Cervical Cancer Screening (BCS) Measure

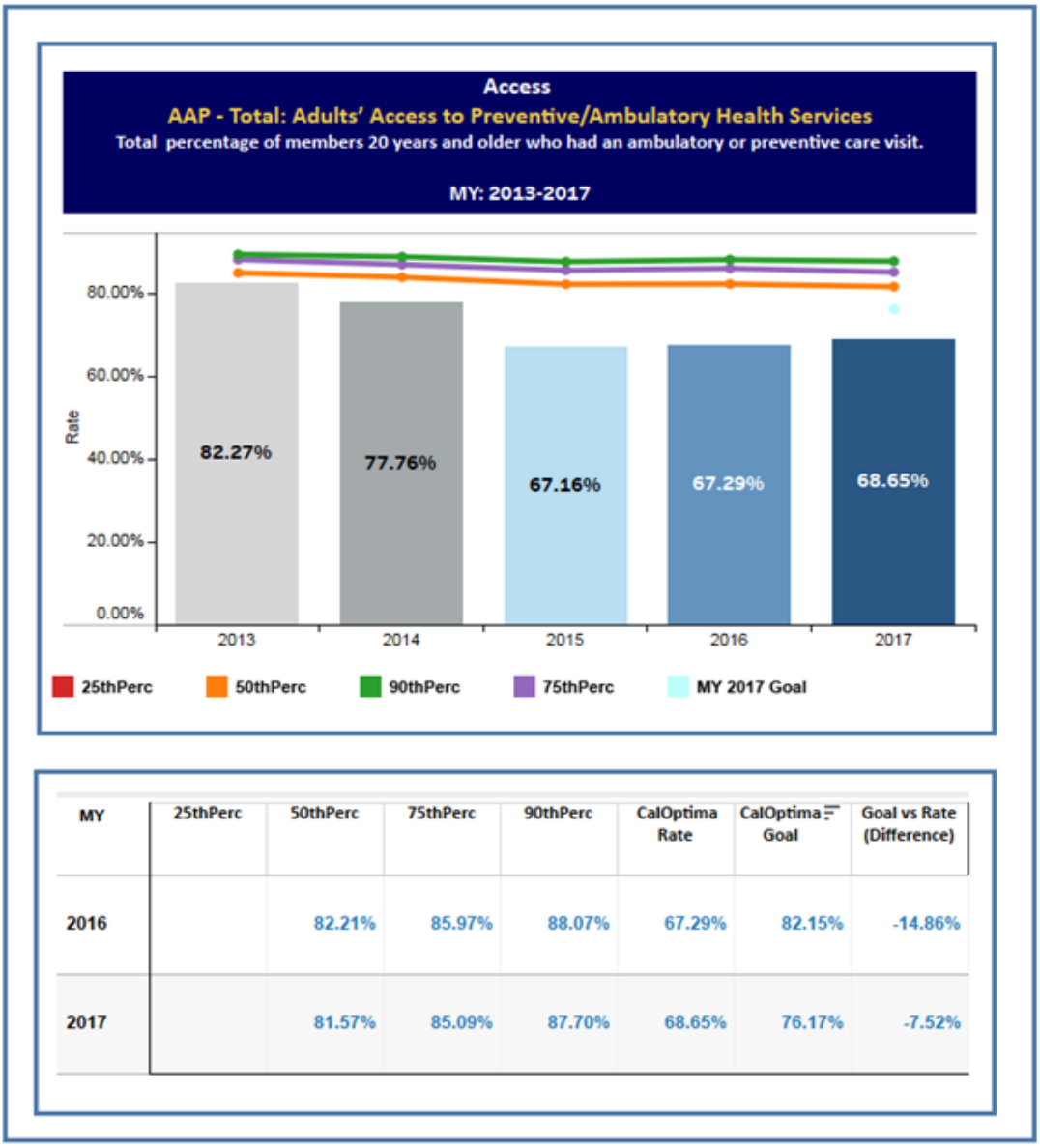


MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	51.82%	60.10%	66.01%	70.68%	60.24%	58.48%	1.76%
2016	48.18%	58.48%	65.90%	70.80%	52.93%	55.94%	-3.01%

This year, CalOptima met our goal and achieved the 50th percentile of the NCQA Quality Compass benchmarks. This is a statistically significant improvement from last year. The CCS measure rates have been fluctuating in the past five years, but there was an increase in screenings this year. CCS is a challenging measure as the population is quite large (131,000+) and there have been some changes in the membership in 2014 due to the Affordable Care Act. A tremendous amount of effort was put into developing Women's Health initiatives to increase this measure. YTD (as of November 2018) the measure is performing better when compared to the same time in the prior year.

Overall, preliminary assessment of the member incentive programs shows that there were low participation rates for the two incentive programs. However, the momentum of the rates moving upward is reflected in the cervical cancer screening measure. CalOptima will continue our member incentive initiatives and have transitioned the program to run year-round to improve participation rates and maintain some consistency with our promotional efforts.

Access to Preventive/Ambulatory Health Services (AAP)



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016		82.21%	85.97%	88.07%	67.29%	82.15%	-14.86%
2017		81.57%	85.09%	87.70%	68.65%	76.17%	-7.52%

This measure includes majority of the Adult Medi-Cal population (296,213 members). Due to the large population, we narrowed the focus to only target Medi-Cal members between the ages of 45-64 years. According to the November 2018 Prospective rate, CalOptima is performing better when compared to the same time last year. The AAP measure is also incentivized as part of the P4V program.

MEDI-CAL PERFORMANCE IMPROVEMENT PROJECTS (PIP)

Improving Adult's Access to Preventive/Ambulatory Health Services for Medi-Cal Members 45-64 years:
The AAP PIP project is currently in the Module 4 (PDSA) cycle which launched in quarter 4, 2018. The data collection is in progress.

NEXT STEPS:

The Quality Analytics team will continue to work with our internal departments to leverage our resources and align our goals to improve adult health measures. We will also move forward with the PIP interventions and data collection. An evaluation of the PIP projects will be conducted at the completion of the project in June 2019. CalOptima will continue our member incentive programs and have transitioned the program to run year-round to improve participation rates. We believe the consistency of a year-round member incentive program would reduce confusion of eligible service dates and encourage members to actively engage in preventive health care services. Several measures describe above are also incentivized in our P4V program.

CHILD / ADOLESCENT HEALTH

INTRODUCTION:

In following CalOptima's mission of providing members access to quality health care, important consideration is placed on starting that care early. The well-being of our members is our goal. Beginning the conversation during the Child and Adolescent years provides better chances for a healthy start. When children are experiencing a stressor, such as medical or mental health symptoms, this impedes their ability to function well. When children are healthy, they can learn, grow and be productive as they are meant to be. For parents, caring for a child or children facing health concerns can be a challenge and impacts other social factors in maintaining the family. CalOptima recognizes the importance of preventive health care and commits to impactful, collaborative projects on a regular basis.

QI ACTIVITIES:

Behavioral Health Depression Screening:
In the 2016 Annual Report on the Conditions of Children in Orange County, emphasis was placed on the need for active preventive care for adolescents due to an increase of 47 percent from 2008 in children and teens being hospitalized for major depression and other mood disorders (San Ramon, 2016). In response to local and national statistics, the US Preventive Task Force recommended screening for persons 12-18 years of age to identify Major Depressive Disorder in teens, leading to treatment and improved outcomes for later life. Given the alarming local statistic and CalOptima's position as the Medi-Cal health plan for Orange County, the CalOptima Board of Directors approved the Depression Screening Incentive plan in April of 2016. The program addresses children's mental health and is designed to increase the rate of depression screening at the annual visit of members who are turning 12 years old, the beginning of adolescence. This began as a two-year project.

CalOptima is paying a stipend to all providers who conduct the depression screening, bill for this screening and provide a follow up care visit during a 2-year pilot initiative. BH has developed an informational packet and a process for handling claims, coordinated with departments in provider outreach and utilization monitoring to meet the objective.

Children with and Attention Deficit–Hyperactivity Disorder (ADD)

The goal of follow up care for members with a new prescription and diagnosis of ADD is to ensure that children, ages 6-18, diagnosed with ADD and prescribed a new medication for the first time, are seen by the prescribing provider for a follow up visit at least two times after that initial prescription. This visit is meant to ensure the member is doing well or to make changes to the planned intervention. BHI actively reviews the Clinical Practice Guidelines (CPG) for treating ADD and posts and distributes updates in provider and member newsletters when necessary. BHI collaborates with external partners on educational events emphasizing the importance of follow up care. The BHI Work Group meets monthly to review trends. This year the previous year data was pulled to review and assess for opportunity to improve follow up by addressing specific providers or clinic sites with high rates of services provided for initial but not follow up care. A second data pull was requested to compare the two data sets and determine the top 10 and top 20 providers for Medical Director outreach. This will occur prior to year-end. Additionally, Provider Relations representatives will deliver education information to these same providers on their regular visit to remind them about the need to follow best practices.

Shape Your Life program

The Shape Your Life (SYL) program was implemented to address the number of overweight and obese youth in the CalOptima membership population. To improve member's health behaviors and member-provider relationships, specific program criteria was developed and introduced including evaluation tools (pre/post) and incentives for both members and providers. The program soft-launched on April 1, 2018 with group classes and member incentives which rolled into full implementation in July 2018. Program eligibility criteria consist of members between the ages of 5-18 with a BMI percentile greater than or equal to the 85th percentile. This program was initiated to: 1) increase youth member access to weight management programs, 2) increase doctor-patient relationships regarding healthy weight and nutrition and physical activity counseling, 3) increase member nutrition and physical activity knowledge and behaviors, and 4) improve HEDIS WCC measures.

Members who complete a minimum of six SYL classes and go to a follow-up visit with their PCP after completing the classes are eligible for an incentive. In addition, providers that complete follow-up visits with these members are eligible for an incentive. CalOptima highly encouraged providers to align the follow-up appointment with the HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children (WCC) services/codes including; BMI percentile, counseling for nutrition and counseling for physical activity. All program activities are ongoing and continue year-round.

CalOptima Day — Health and Wellness Events

This year, CalOptima continued to focus our efforts in improving child and adolescent health, particularly the well-care and immunization measures. CalOptima adapted from last year's "CalOptima Day" initiative that promoted well-care visits and immunizations at targeted high-volume provider sites. These events are co-hosted with a HN and provider/clinic office. At this event the provider/clinic office will set aside a day and time to host this event just for CalOptima members assigned to the partnering HN. CalOptima members are outreached by the office staff to schedule appointments for the CalOptima Day event. Members are incentivized with a $25 Stater Brothers gift card for completing the health visit (well-care visit and/or immunization). Additionally, the participating provider/clinic offices are incentivized based on a two-tiered incentive program that is based on the number of completed health visits for each event. Offices

are encouraged to reach 30 visits for a half day and 60 visits for a full day, if these numbers are met, they are given the incentive based on the achieved tier level.

The CalOptima Day initiative was implemented to build strong working relationships with our HNs and providers to continuously promote well-care visits and immunizations in their offices. CalOptima provided providers a member registry list and worked with them to reconcile the information so the office can outreach to members. This program ran through the end of December 2018.

Children with Pharyngitis

CalOptima continued to focus our efforts in improving the children with pharyngitis (CWP) measure which has been historically below the 25th percentile of the NCQA Quality Compass benchmarks. However, this measure has shown great improvements and has been trending upward over the past five years. In the past, CalOptima targeted PCPs for education about this measure. This year, CalOptima chose to focus our efforts in outreaching to urgent care centers (UCCs) because many CalOptima members are seen for strep at these centers and are often diagnosed without a strep test. We partnered with CHOC Health Alliance to conduct outreach to the top seven high-volume UCCs. UCCs were provided with their data from the previous year and their office CWP HEDIS rates. CalOptima medical directors went over the HEDIS measure with the urgent care center's leadership and staff, discussed the clinical practice guidelines, and provided rapid strep A test kits to the offices.

TRENDING OF MEASURES/RESULTS

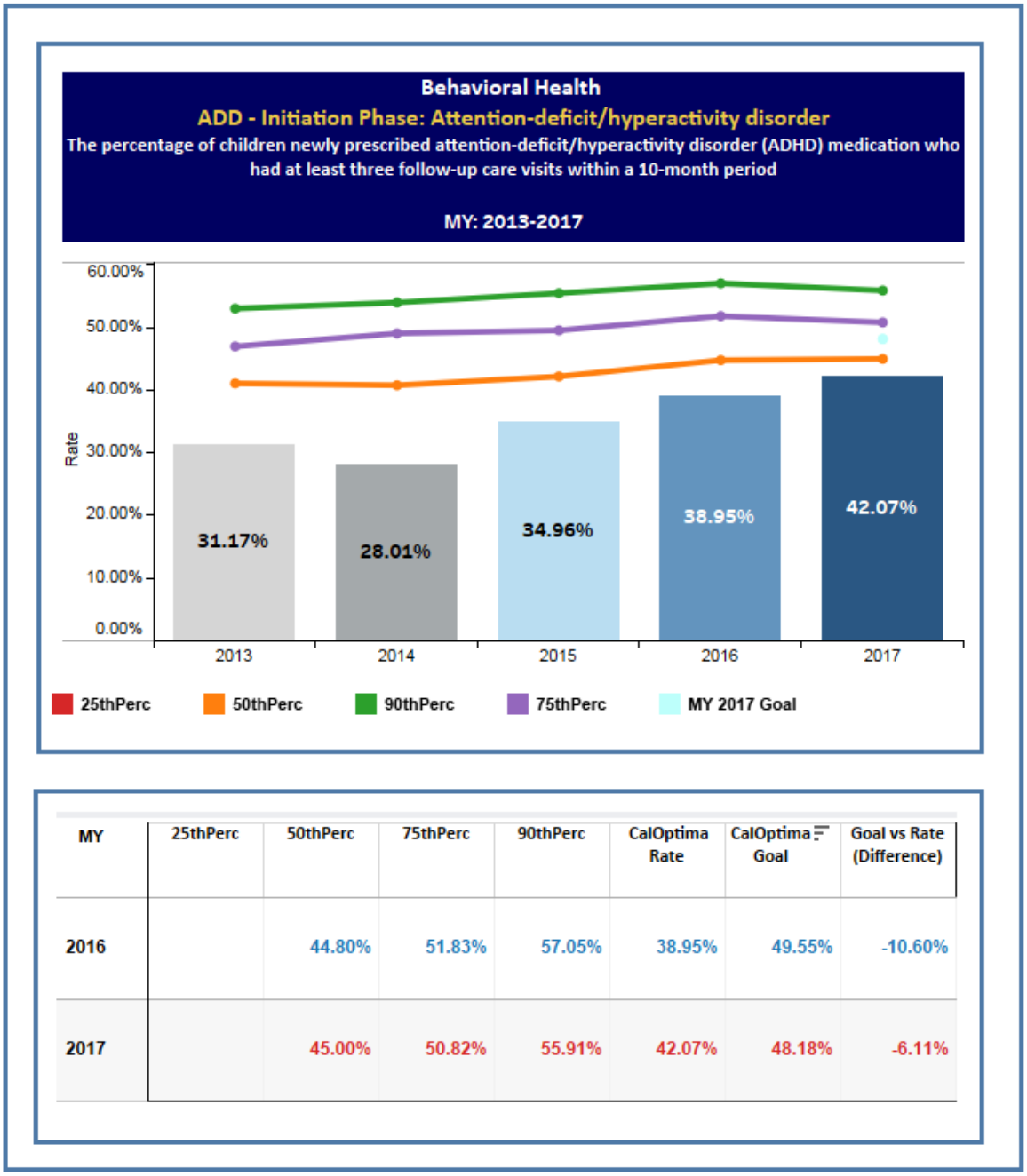
Depression Screenings

DEPRESSION SCREENING UTILIZATION 2018			
	Q1	Q2	Q3
NUMBER OF MEMBERS SCREENED (WITH PAID CLAIMS)	1026	848	768
POSITIVE SCREENINGS (G8431)	155	125	99
NEGATIVE SCREENINGS (G8510)	871	723	669

DEPRESSION SCREENING UTILIZATION 2017			
	MAY/JUNE	Q3	Q4
NUMBER OF MEMBERS SCREENED (WITH PAID CLAIMS)	472	1101	371
POSITIVE SCREENINGS (G8431)	82	173	52
NEGATIVE SCREENINGS (G8510)	391	931	319

Claims are submitted to CalOptima, processed and tracked for depression screenings conducted by a PCP with a 12-year-old member. Analysis of the results allows the BH team to determine where opportunities for intervention by the behavioral health department exist. The quarterly results are presented to BHQI, QIC, QAC and the CEO for review and questions.

Pediatricians who participate receive an incentive payment of $50 upon completion of the screening and submission of a special claim to CalOptima. Supported by a $1,000,000 allocation by CalOptima's Board of Directors, the program began May 1, 2017, and to date has provided incentive payments for a total of 6, 336 depression screenings.



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016		44.80%	51.83%	57.05%	38.95%	49.55%	-10.60%
2017		45.00%	50.82%	55.91%	42.07%	48.18%	-6.11%

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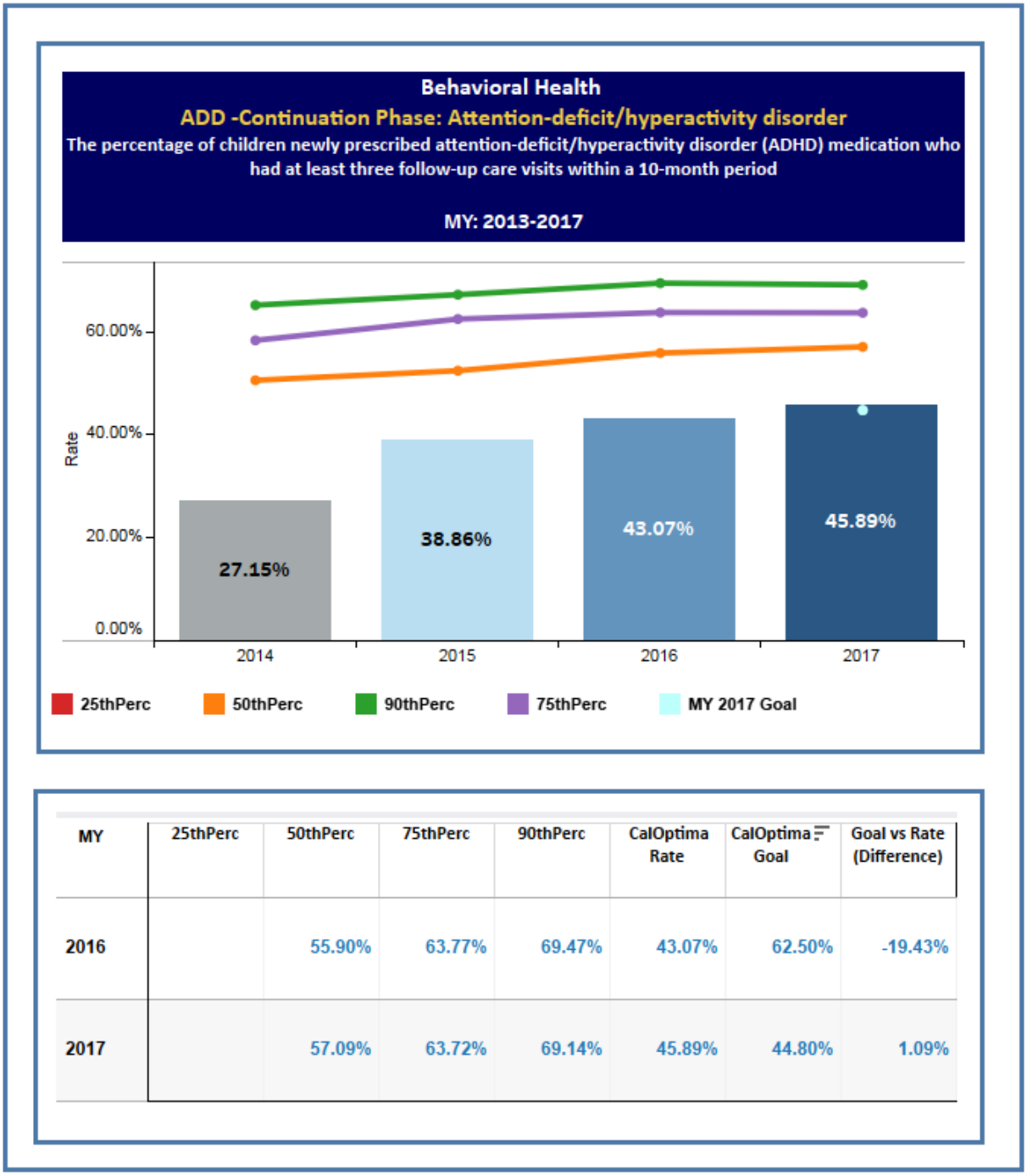


MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016		55.90%	63.77%	69.47%	43.07%	62.50%	-19.43%
2017		57.09%	63.72%	69.14%	45.89%	44.80%	1.09%

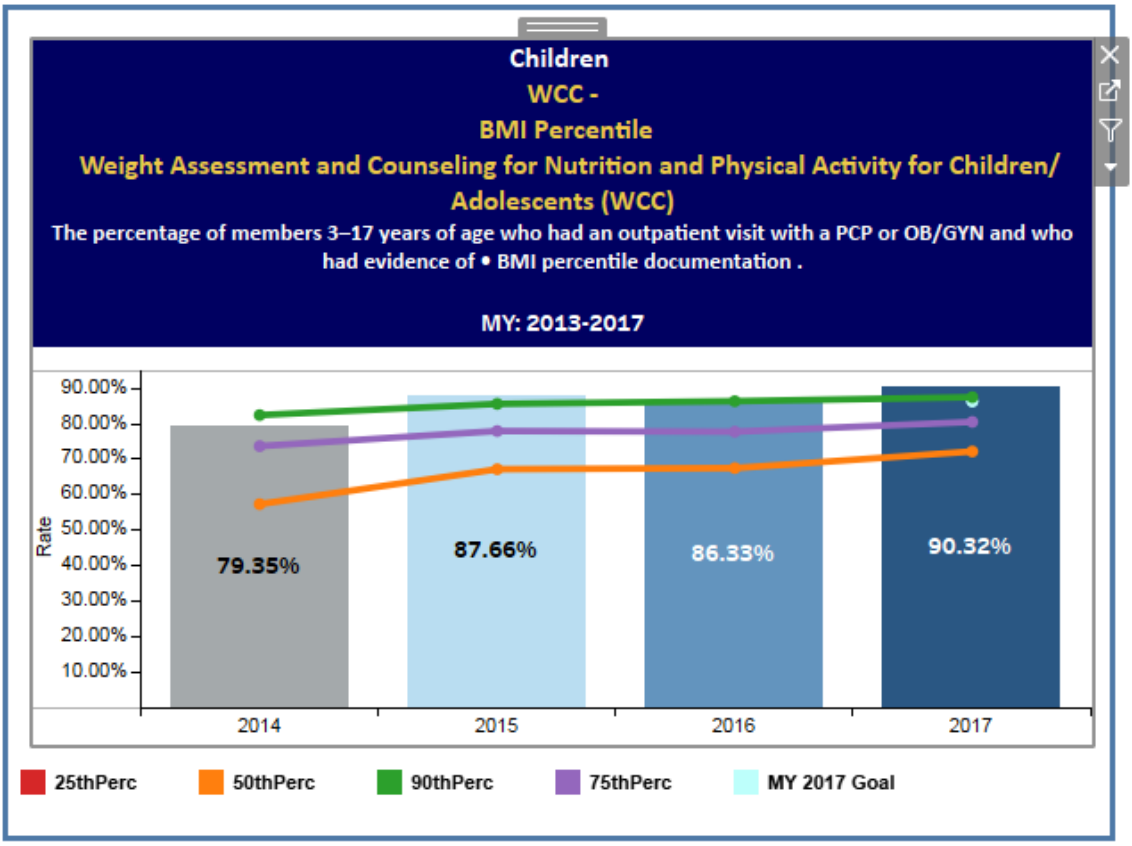
Analysis over the past five consecutive years of rates for follow up visits with members prescribed a first medication for ADD diagnosis have been positive and we continue to see an increase. The initiation phase is below the 25th percentile for HEDIS 2018 (Measurement Year 2017) however CalOptima achieved the goal of 44.80% for continuation of care. This was a significant accomplishment to get to this point by our fifth year working with this population.

There are still challenges to ensuring follow up visits are taking place for a variety of reasons, including providers not coding for the visits, members not seeing the same provider who

prescribed the medication, or members not able to make a visit within the prescribed timeframes for best care. Members are being seen for follow up visits, yet not as often as we would hope. It is common knowledge that a small portion of patients prescribed a medication will start to feel better and stop taking the medication. As a result, the member may discontinue maintenance of care. For this population, there are added layers since the patients are minors and must rely on their parents for initiation and continuation of care. In some instances, location and available appointment times may present a challenge for the member or may not meet the needs of the parents who may face challenges in arrangements to make their appointments.

Shape Your Life program

The SYL program is still in its infancy stages. The SYL program cannot demonstrate data trends thus far due to the recent implementation date. The measures to be tracked include the WCC HEDIS measures, member BMI variations, and participation rates. It is anticipated that WCC HEDIS measures will plateau prior to improving. These measures will need to be tracked for multiple years to see the impact SYL has had to the CalOptima youth population.



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017		72.22%	80.54%	87.50%	90.32%	86.37%	3.95%
2016		67.54%	77.78%	86.37%	86.33%		

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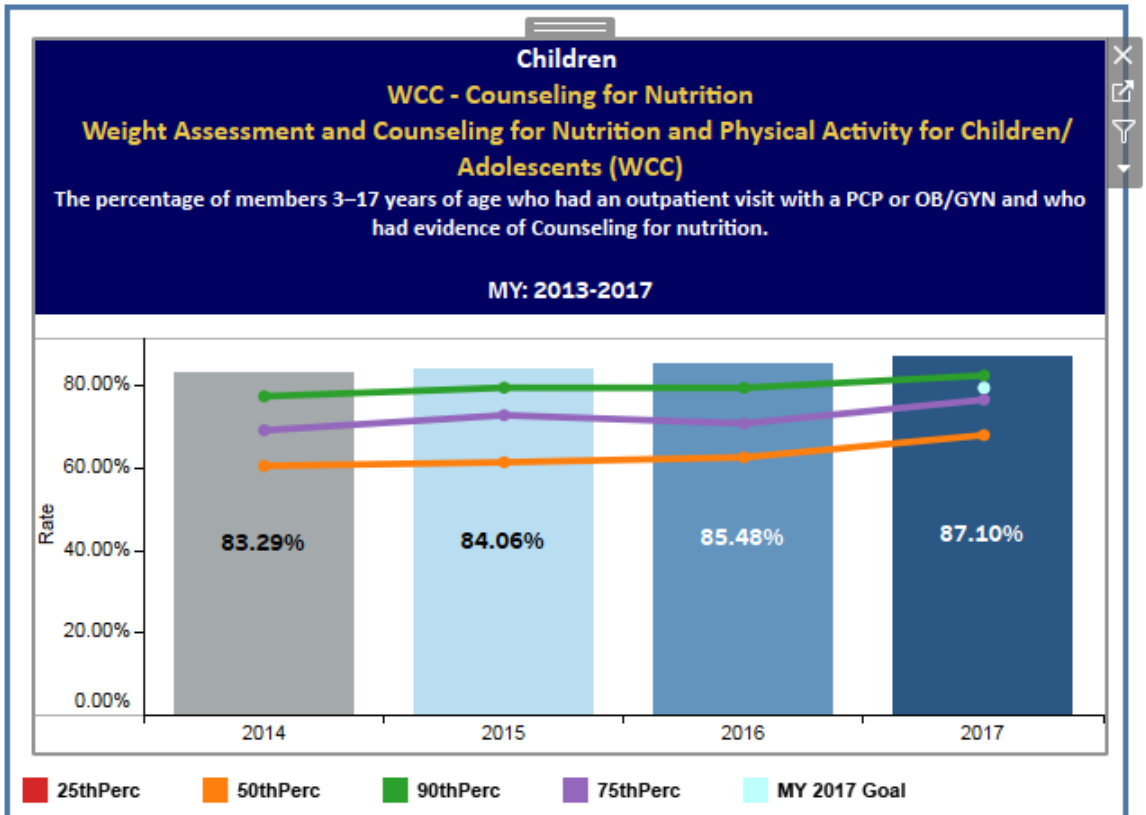

MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017		68.05%	76.64%	82.53%	87.10%	79.52%	7.58%
2016		62.65%	70.88%	79.52%	85.48%		

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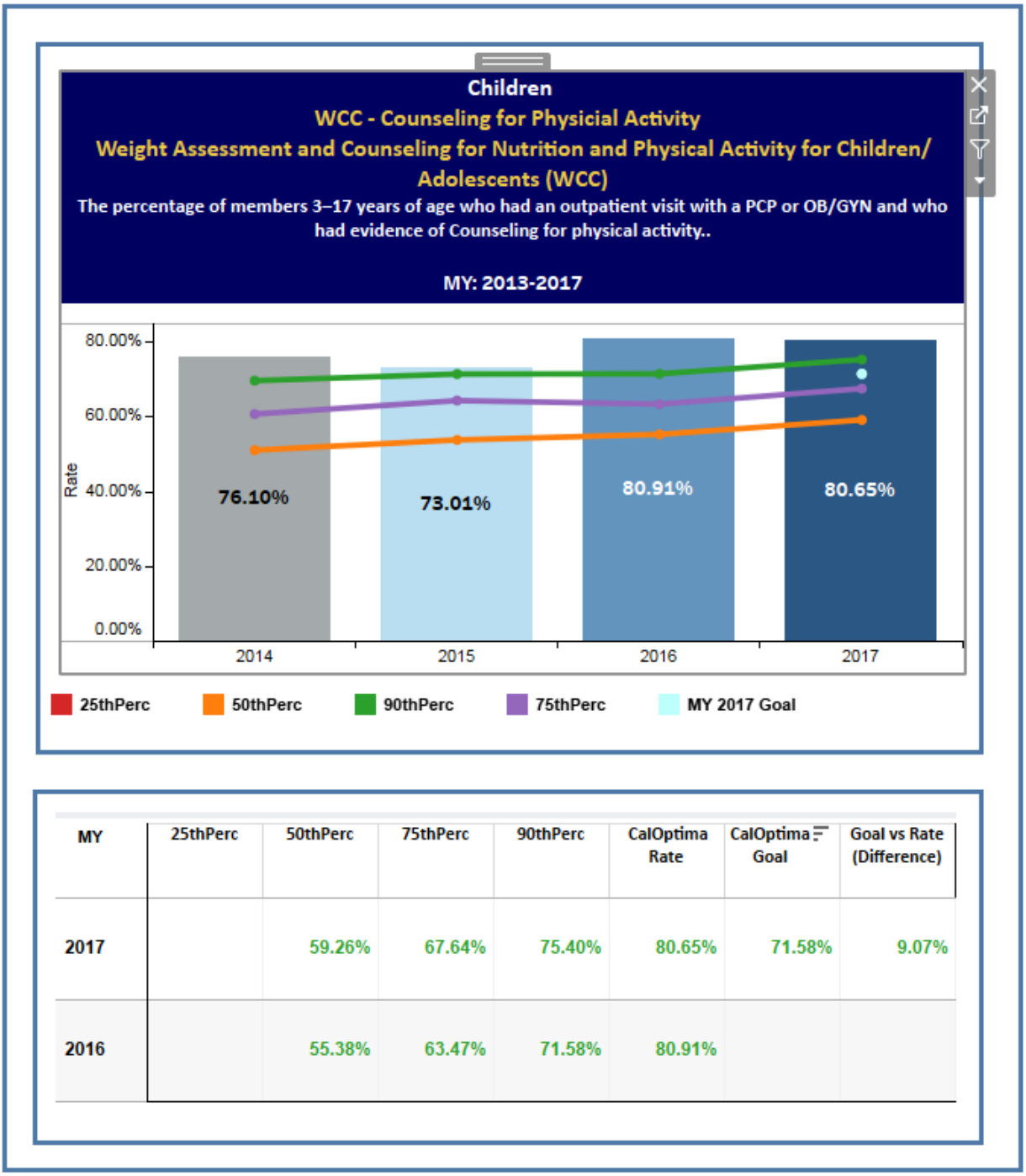


MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017		59.26%	67.64%	75.40%	80.65%	71.58%	9.07%
2016		55.38%	63.47%	71.58%	80.91%		

The WCC measure has been performing well at the 90th percentile of the NCQA Quality Compass benchmarks for all three sub-measures (Counseling for Physical Activity, Counseling for Nutrition and BMI Percentile).

CalOptima Day Events

CalOptima conducted ten CalOptima Days through the end of December 2018.

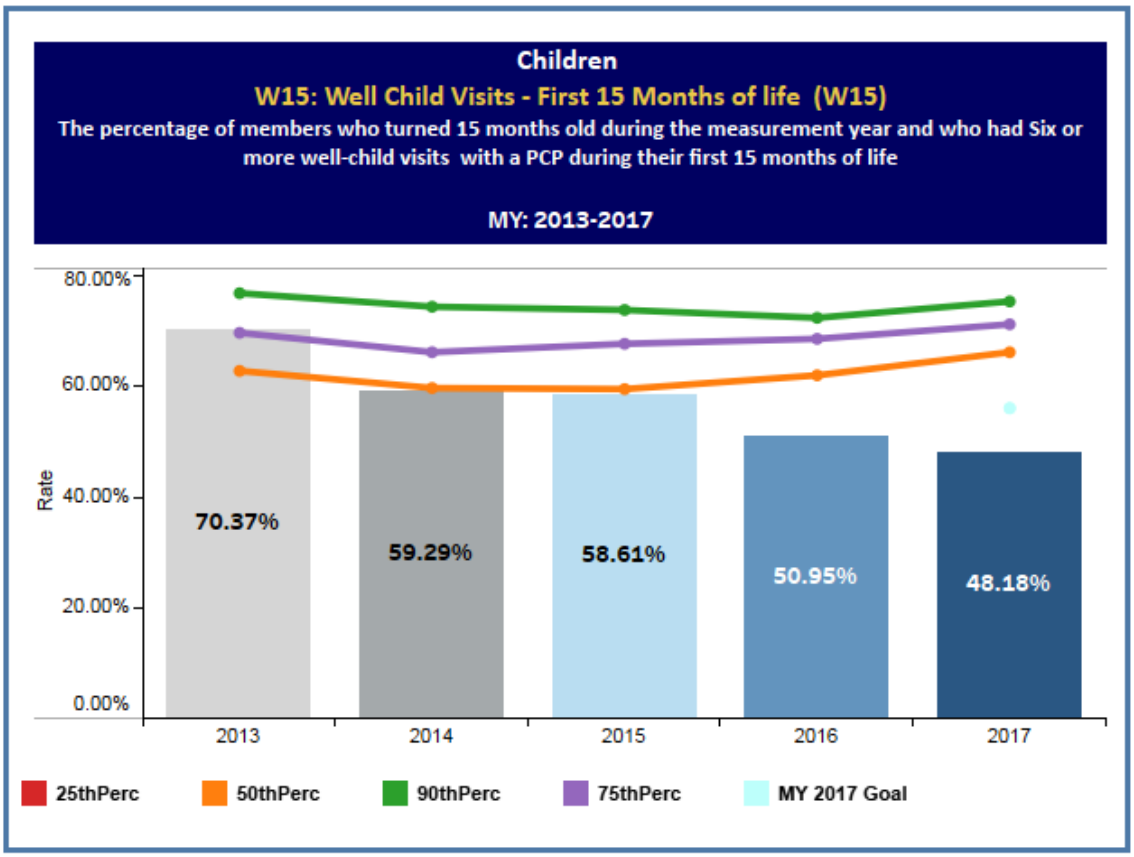
Clinic	Event Date	Scheduled	No-Show	Walk-In	Attended	Attendance Rate
South Coast Pediatrics	7/26/2018	93	16	0	77	82.80%
CHOC-Orange Clinic	8/13/2018	30	12	0	18	60.00%
San Juan Pediatrics	8/15/2018	87	22	0	65	74.71%
Memorial Care	9/22/2018	63	19	0	44	69.84%
Pediatrics & Neonatology Medical Group of Orange County	10/17/2018	78	15	0	63	80.77%
San Juan Pediatrics (2nd event)	11/7/2018	80	20	6	66	82.50%
Bolsa Medical Group	11/20/2018	41	15	6	26	78.05%
South Coast Pediatrics (2nd event)	11/30/2018	107	38	0	69	64.49%
Strong Kids (2nd event)	12/4/2018	94	29	0	65	69.15%
Pat Kouwabunpat, MD	12/17/2018	13	5	7	15	115.38%
Total		**686**	**191**	**19**	**508**	**74.05%**

Results for the CalOptima Day initiative show great improvements from the previous year. There were three additional events this past year. The attendance rate increased from 63.75% in 2017 to 74.05% in 2018 (+10.30%) with the ten events. This is most likely due to the following factors: 1) the tiered provider incentive encouraged a larger number of over-booking for each event to reach the goal to receive the Tier 2 payment, 2) there was better overall planning and CalOptima incorporated lessons learned from the previous year, and 3) there was an increase in members who attended the events from 2017 to 2018. Based on success of this initiative in 2018, we are recommending the continuation of this initiative in 2019 with expansion to more provider offices.

Child and Adolescent Well-Care HEDIS Measures

When looking at HEDIS trending for the past five years, some of the child and adolescent well-care measures have been trending downwards which is why CalOptima selected to focus on improving those rates. The Childhood Immunization Status measure (Combo 10) and all the child and adolescent well-care measures are incentivized through the P4V program.

Well-Care in the First 15 Months of Life (W15)

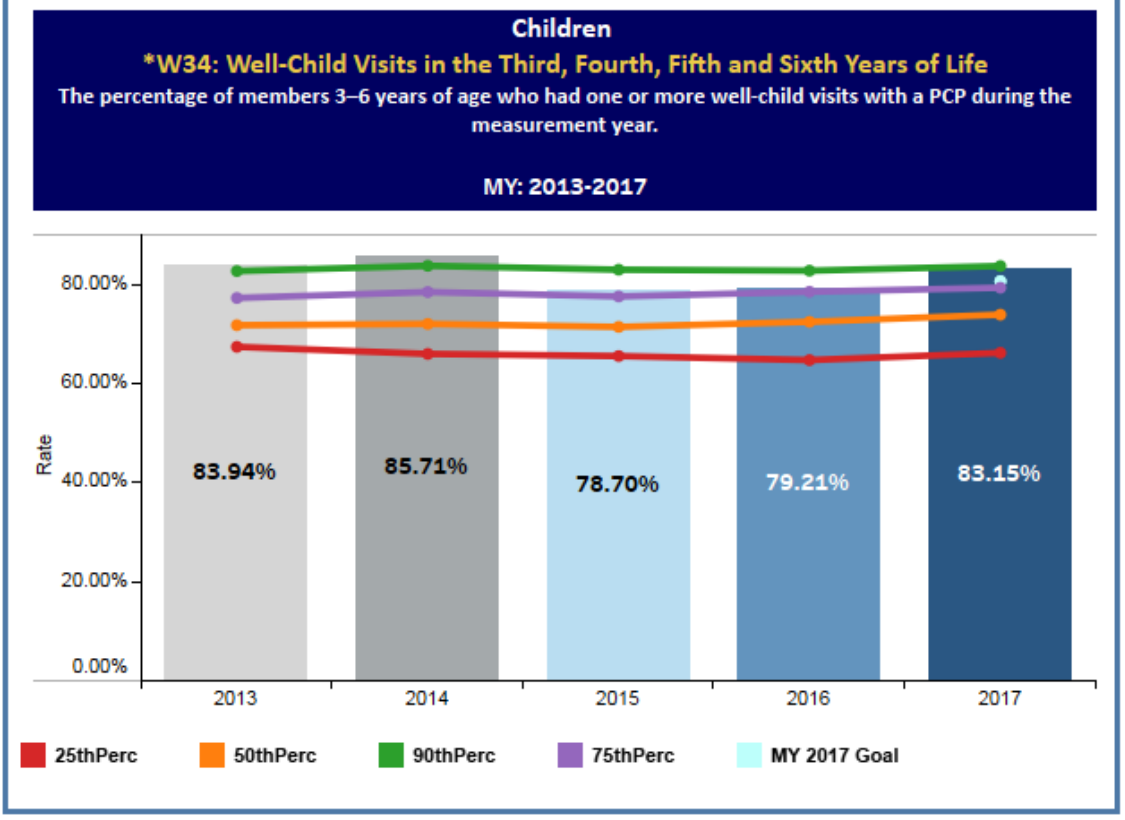


MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016		62.06%	68.66%	72.46%	50.95%	59.57%	-8.62%
2017		66.23%	71.29%	75.43%	48.18%	56.11%	-7.93%

The W15 measure remains an area of focus for CalOptima as there has been a decrease in our rates for the past five years. CalOptima currently performs below the 50th percentile. One of the barriers associated with this measure is missed appointments. When a child misses one of the six well-care visits required to meet the HEDIS criteria, it is very challenging for them to catch up and be on track within the 15-month timeframe. CalOptima has been working closely with our targeted provider offices to provide them with the list of members who are due for a visit based on our records. This would help the offices identify members who are due and/or reconcile

member information with CalOptima. This measure is also incentivized as part of the P4V program.

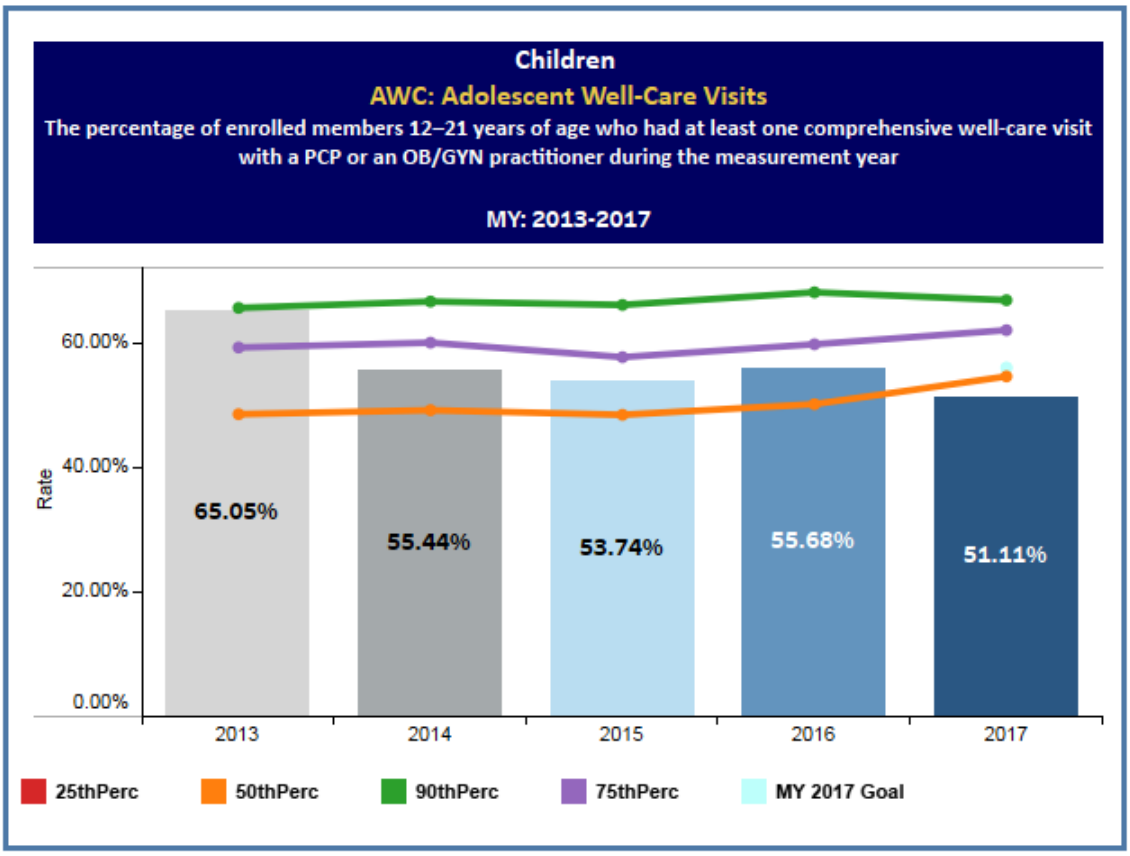
Well-Care Visits for 3-6 Years (W34)



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	66.18%	73.89%	79.33%	83.70%	83.15%	80.64%	2.51%
2016	64.72%	72.45%	78.51%	82.77%	79.21%	80.27%	-1.06%

The W34 measures has been steadily increasing in the past three years. CalOptima is performing well in this measure and have met goal for HEDIS 2018. We currently perform at the 75th percentile and just below the 90th percentile NCQA benchmark by less than 1%. This measure is also incentivized as part of the P4V program.

Adolescent Well-Care (AWC)



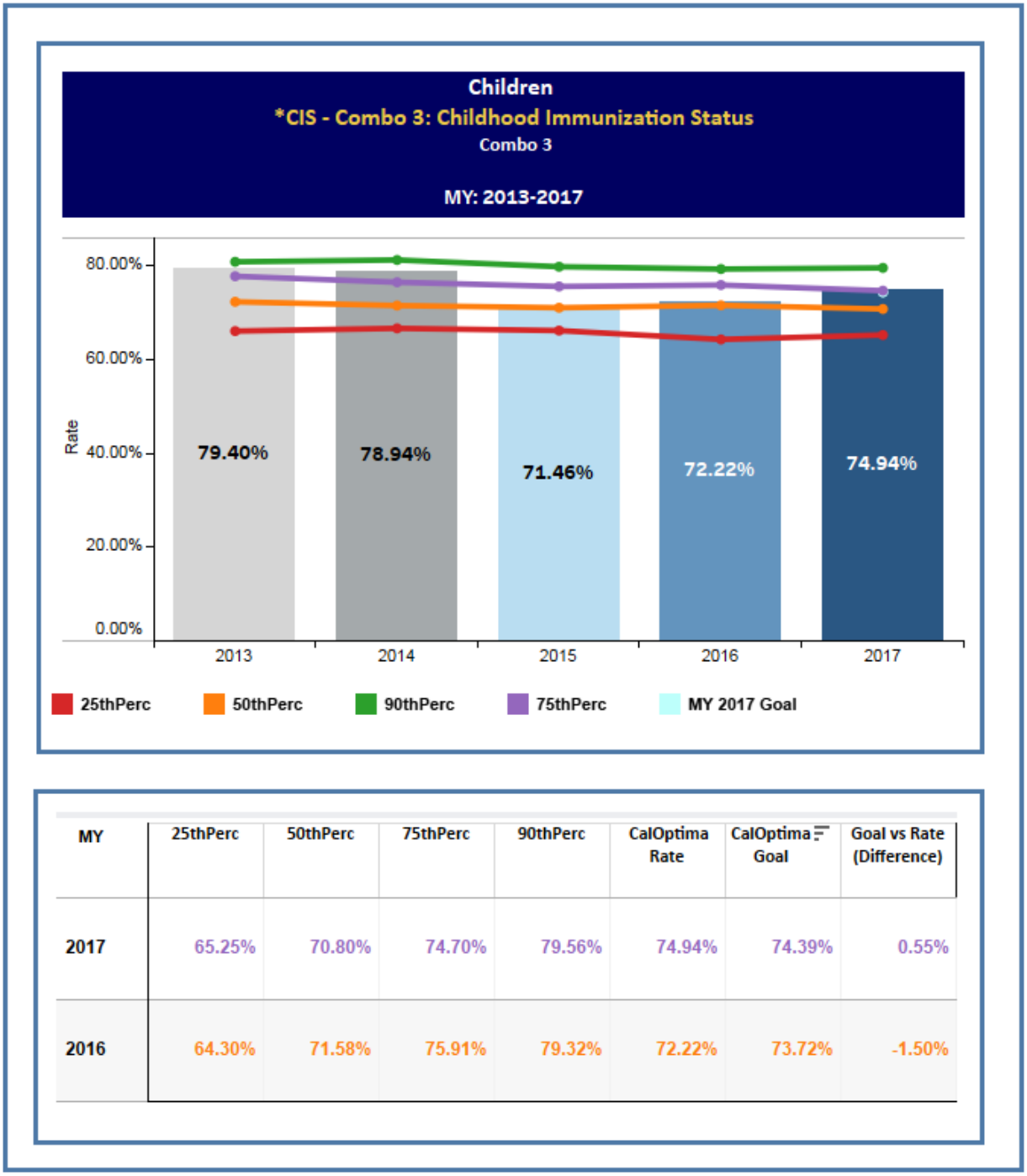
MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017		54.57%	61.99%	66.80%	51.11%	55.96%	-4.85%
2016		50.12%	59.72%	68.06%	55.68%	55.47%	0.21%

The AWC measure has been trending downward in recent years. CalOptima did not meet our goal of 55.96% this year and we are currently at the 25th percentile of the NCQA Quality Compass benchmark. This measure is also incentivized as part of the P4V program.

Child and Adolescent Immunizations Measures

Childhood Immunization Status (CIS)

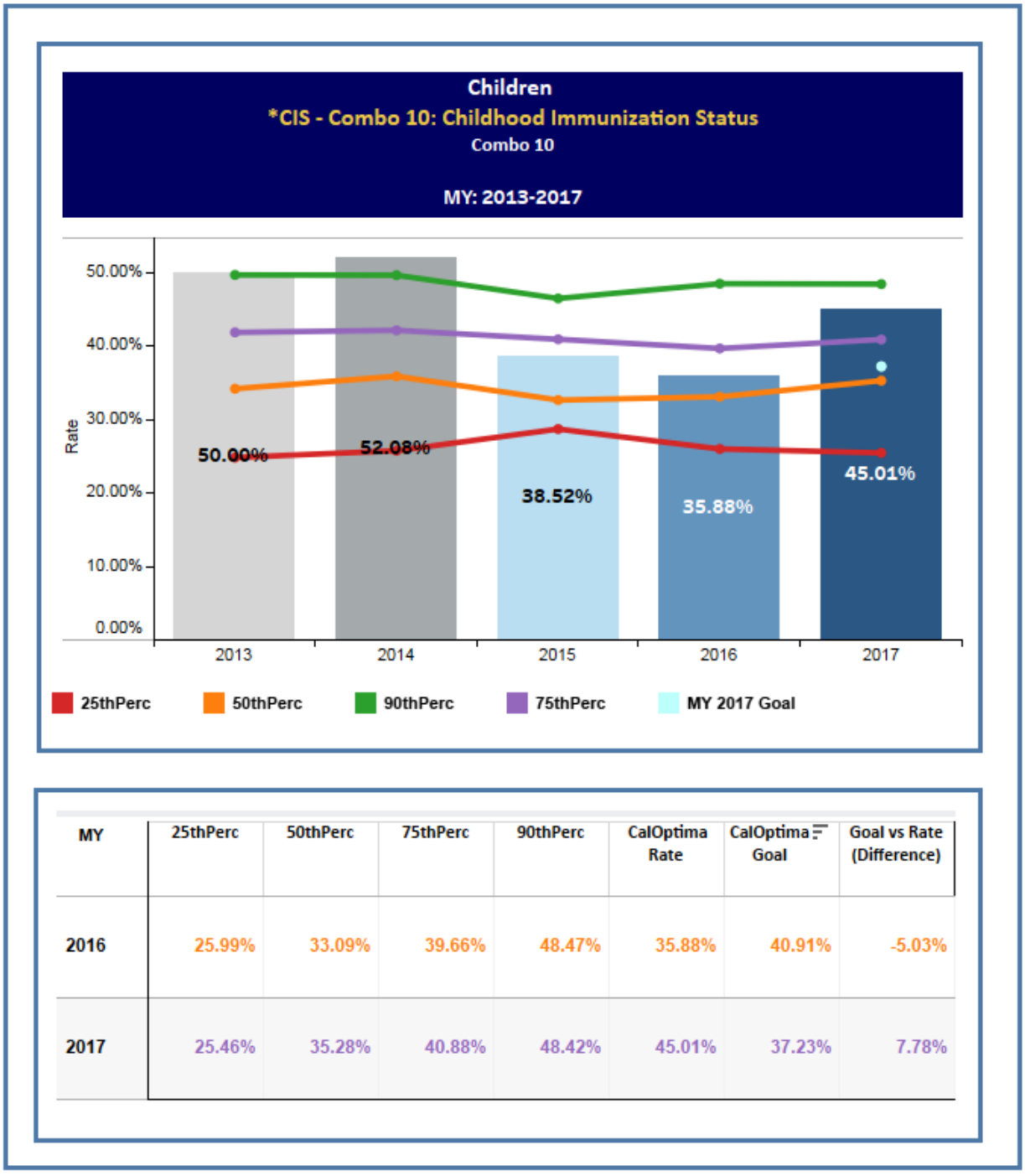
CIS Combo 3



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	65.25%	70.80%	74.70%	79.56%	74.94%	74.39%	0.55%
2016	64.30%	71.58%	75.91%	79.32%	72.22%	73.72%	-1.50%

The CIS Combo 3 sub-measure has been trending upward for the past three years. CalOptima has met goal and achieved the 75th percentile according to the 2017 NCQA Quality Compass benchmark.

CIS Combo 10



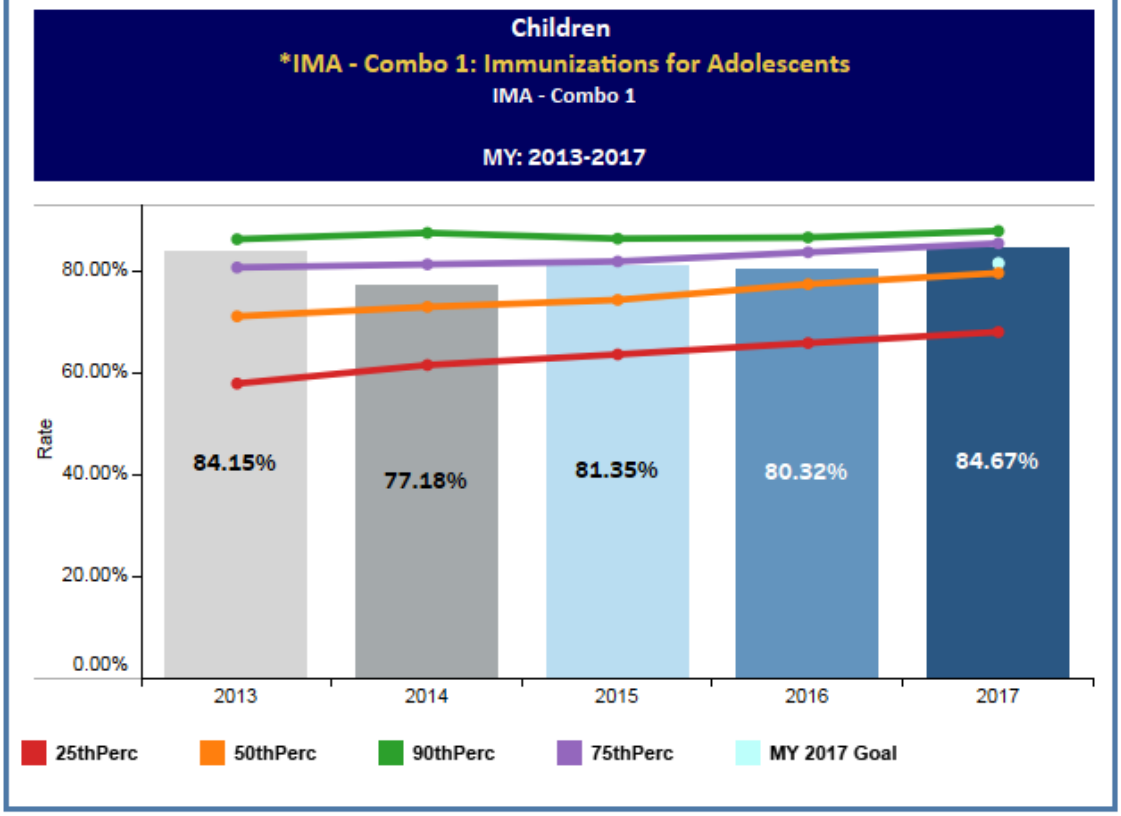
MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016	25.99%	33.09%	39.66%	48.47%	35.88%	40.91%	-5.03%
2017	25.46%	35.28%	40.88%	48.42%	45.01%	37.23%	7.78%

The CIS Combo 10 rate has gradually increased in the past three years. CalOptima has met our goal for this year and achieved the 75th percentile for this measure. It should be noted that this measure showed statistically significant improvement compared to last year. This could be attributed to HEDIS data improvements in which the California Immunization Registry (CAIR) data issue was addressed in 2017. CalOptima was not receiving updated registry information

from CAIR and therefore was not receiving all data for our members. In addition, CalOptima started receiving supplemental data from Kaiser which also addressed the data gaps. CalOptima continued to move forward and added the immunization measures onto our P4V program.

Immunizations for Adolescents (IMA)

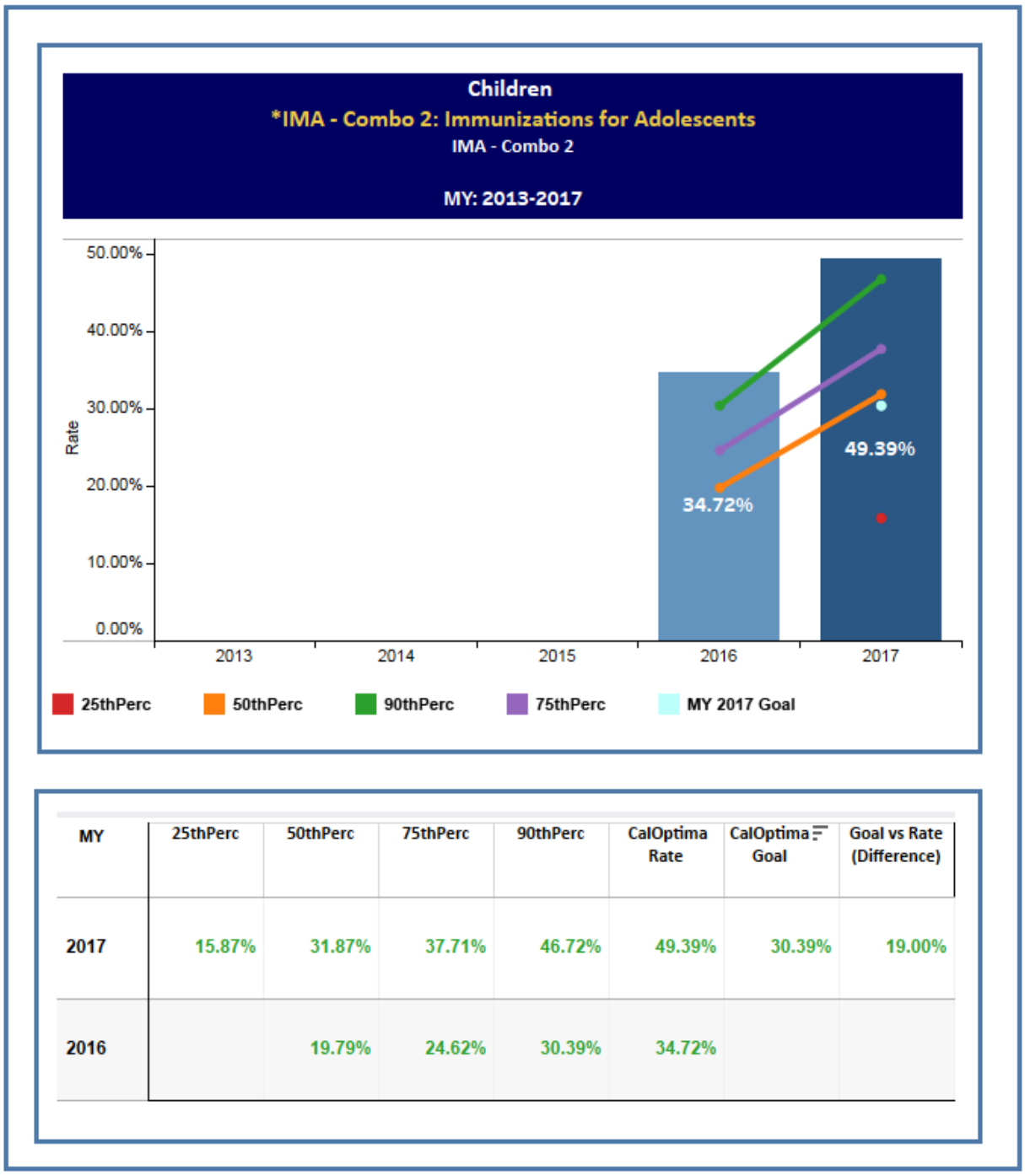
IMA Combo 1



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016	66.03%	77.62%	83.89%	86.81%	80.32%	82.09%	-1.77%
2017	68.21%	79.81%	85.64%	88.08%	84.67%	81.73%	2.94%

The IMA Combo 1 sub-measure has been steadily increasing in the past four years. CalOptima is at the 50th percentile according to the 2017 NCQA Quality Compass benchmark.

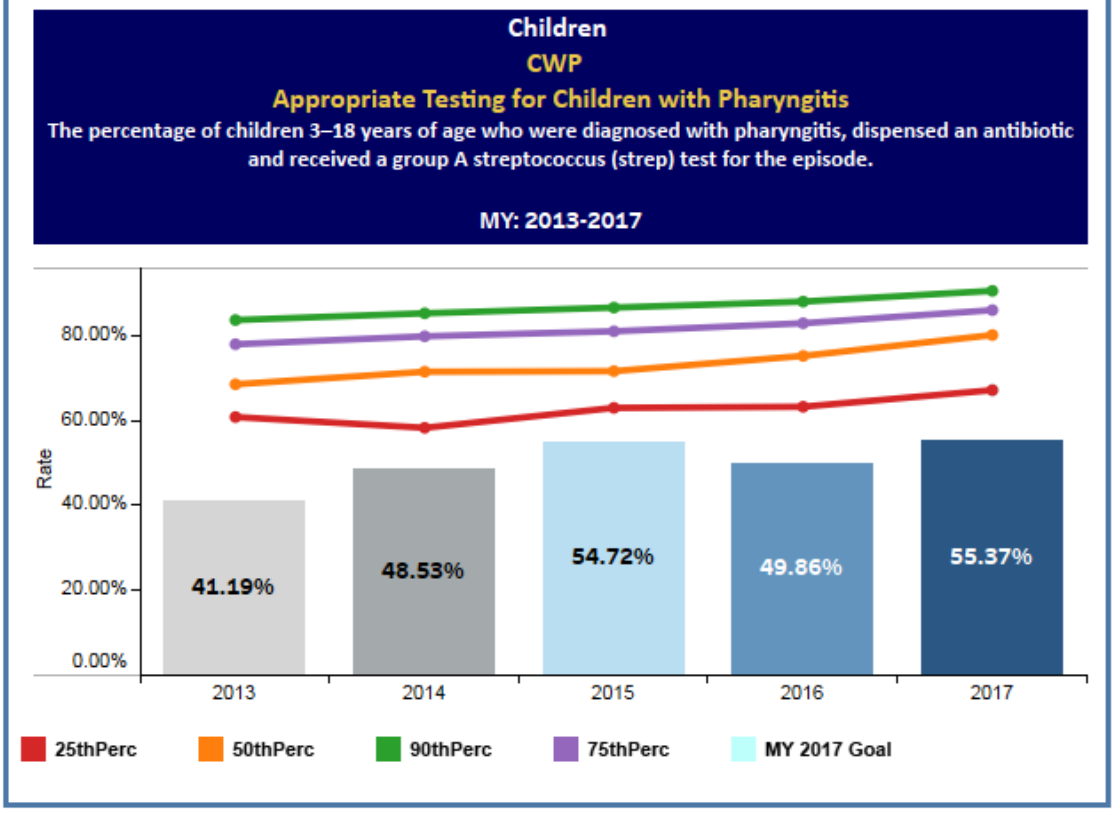
IMA Combo 2



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	15.87%	31.87%	37.71%	46.72%	49.39%	30.39%	19.00%
2016		19.79%	24.62%	30.39%	34.72%		

The IMA Combo 2 sub-measure recently became a HEDIS measure in 2017 therefore, there are only trending results for two years. This measure has been performing very well and CalOptima is at the 90th percentile according to the 2017 NCQA Quality Compass benchmark. In addition, there was statistically significant improvement for IMA Combo 2 this year.

Children with Pharyngitis (CWP)



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	67.15%	80.13%	85.99%	90.53%	55.37%	67.15%	-11.78%
2016	63.24%	75.21%	82.90%	88.00%	49.86%	63.24%	-13.38%

The CWP measure is a challenging measure but has gradually improved for the past five years except for measurement year 2016. Although CalOptima has not met the goal yet, there was statistically significant improvement from HEDIS 2017 to HEDIS 2018. CalOptima changed our outreach efforts this year to target UCCs due to their low performance which heavily impacts the CWP measure. CalOptima worked with our HN partner, CHOC Health Alliance, to conduct targeted outreach to leadership at the UCCs. Preliminary analysis shows some improvements with UCCs coding and documentation of pharyngitis events that occurred at the UCCs. We anticipate that there will be more improvements in the rates for next year due to this shift in

strategy. CWP remains a P4V measure and will be recommended to continue as one for next year.

NEXT STEPS:

Behavioral Health: The depression screening initiative aims to assess progress of early detection, intervention, and treatment of behavioral health in the adolescent population through collaborative work between medical and behavioral health providers. The results and feedback from providers and committee partners has been positive thus far. Screenings and data will continue to be processed through May 2019 when analysis and next steps will be decided. There have been over 4,700 depression screenings since this program began. A little over 700 screenings were positive for depression and the remaining 4,000 screened negative. There has been positive feedback about the program overall. Some challenges for providers include comfort level for the follow up once a screening is positive. BH has provided guidance on handling next steps and ensuring proper claims process is followed to participate in the program. Overall, this has been successful.

BHI has been actively working to improve the follow up care for ADD since 2013. Measured in claims and pharmacy records, we can see the progress towards that goal. This measure has improved over the last three years by a small margin. Outside of supporting providers with CME events and members with newsletters and information about the diagnosis and importance of follow up care, there was no active intervention during 2018. Results continued to improve, meeting the anticipated 50th percentile goal. The significance of this is not so much in the numbers, but the fact that more providers were able to speak with members sooner and frequently to ensure they are doing well.

Health Education: It is recommended that the SYL program continues to: 1) expand access the CalOptima members, 2) continue to improve coordination with providers and community sites, 3) record program data and 4) continue member and provider incentives. In addition to the current pre/post survey completed by members it is recommended that next year a follow-up (3-6 month) post program survey is developed to determine if members adopted health behaviors temporarily or continued long-term.

Quality Analytics: It is recommended that CalOptima continue our efforts in expanding the CalOptima Day initiative to more providers in 2019 and start the initiative earlier in the year. This way the well-care and immunization measures have a larger number of members in the denominator for provider offices to outreach to before they pass the age to meet the HEDIS measure requirements. CalOptima will continue to work closely with our targeted provider offices to provide them with the list of members who are due for a visit based on our records. This would help the offices identify members who are due and/or reconcile member information with CalOptima.

QA recommends continuing our outreach efforts with UCCs for the CWP measure and look at high volume PCP offices for opportunities for improvement. We will also collaborate closely with our internal departments to leverage resources available and have a joint effort in promoting quality initiatives to our HN and provider partners.

SUMMARY:

CalOptima is in a unique position to have a positive impact on member lives through optimal care and education. Members look to the medical and behavioral health providers for answers and help with their well-being. It is our hope to be able to provide the necessary supports and resources to guide our members through a healthy lifestyle. Starting the conversation and relationship early is essential to meeting this goal. Health Education, BHI and Quality Analytics will continue to work closely with our members and each other to develop a robust, well represented quality care system for our young members.

REFERENCES:

San Roman, Gabriel, (2017). Kaiser Permanente's Mental Health Screenings for Preteens Expand Beyond OC, May 17, 2017.http://www.ocweekly.com/content/printView/8116276 [5/23/2017 9:09:43 AM]

MATERNAL CHILD HEALTH

INTRODUCTION:

CalOptima on average serves between 7,000 to 8,000 pregnancy members annually. Since women who have early, and constant prenatal care have babies with better health CalOptima strives to ensure our members have access to appropriate care and resources when pregnant and after delivery. CalOptima has enhances services provided to our pregnant members and new moms over the past year to provide better outcomes for moms and babies including; development of a new program, Bright Steps.

While the new maternal health program was in development, continued efforts were done to promote prenatal and postpartum health to CalOptima members. Bi-weekly mailings were sent to the prenatal population as identified through pregnancy notification reports (PNRs). Monthly postpartum mailings were sent to members who recently had a live delivery. This year, CalOptima offered a $25 gift card incentive to eligible Medi-Cal members who completed a postpartum visit within 3-8 weeks post-delivery. This member incentive program was available for members that delivered between June 1, 2018 through November 5, 2018.

A tremendous amount of effort was put towards aligning the DHCS contractual requirement of the Comprehensive Perinatal Services Program (CPSP) this year, leading to the development of the recently launched maternal health program – Bright Steps. Bright Steps soft-launched September 1, 2018 with full implementation expected first quarter of 2019. CPSP and Bright Steps provide eligible members activities that include: 1) All medically necessary services for pregnant members per the most current standards, 2) a comprehensive risk assessment, 3) individual care plans addressing obstetrical, nutrition, psychosocial, and health education, 4)

timely high-risk clinical referrals to appropriate specialist and delivery services, and 5) referrals to needed resources.

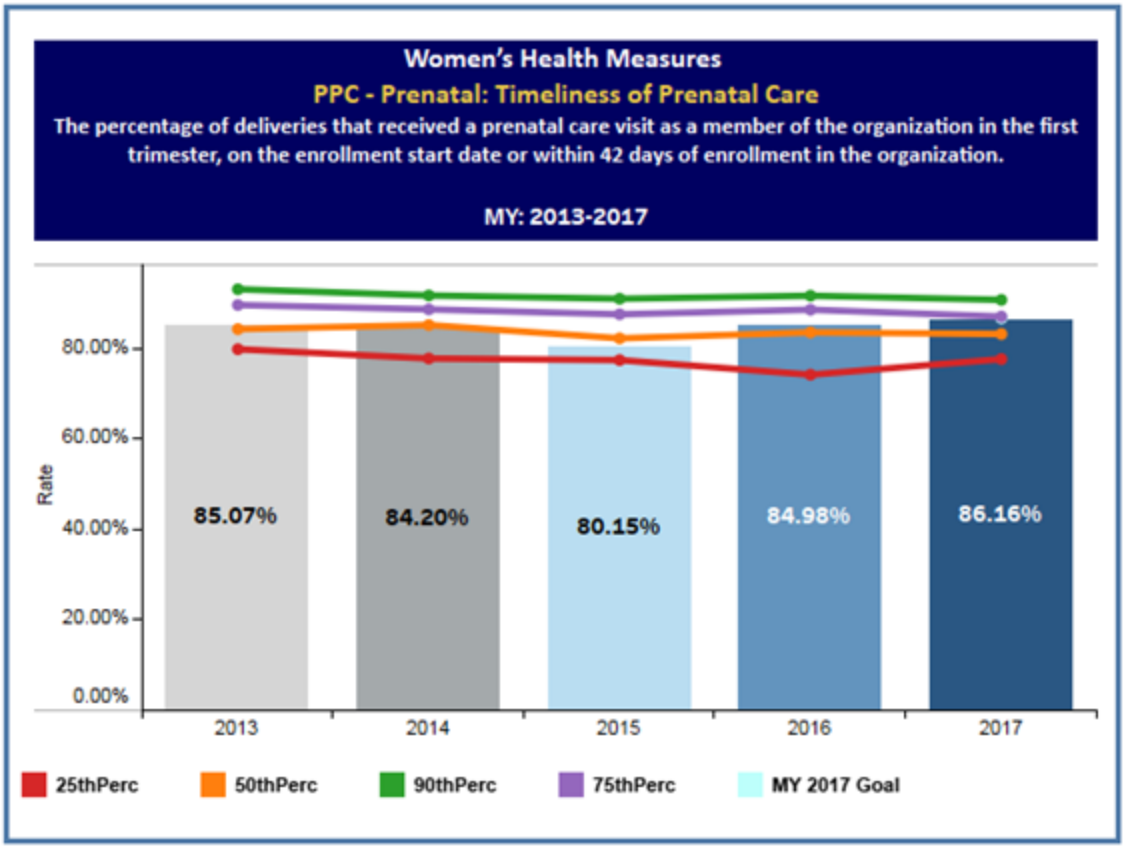
To ensure all members are provided the opportunity for these services, CalOptima educated providers on CPSP certification including requirements for providers to be a contracted CPSP provider through CalOptima Bright Steps. Through provider communications, CalOptima showed support for providers to become CPSP certified, if they are not already. CPSP providers provide obstetrics care as well as the CPSP support services (nutrition and health education, psychosocial and community resources) in their office/clinic. However, CalOptima is aware that not all providers are willing or able to complete the stringent requirements to become CPSP certified. For this reason, Bright Steps was a necessary step in ensuring all members are provided support services.

Bright Steps staff have and continue to fill the gap and provide support services for members that haven chosen to have a provider that is not CPSP certified. Bright Steps staff are comprised of health educators, dieticians, an overseeing medical provider and internal behavioral health employees. Bright Steps staff provide an initial outreach to members and continue with telephonic assessments, done on a trimester basis, including referrals, education and reminders about preventative testing. Staff also outreach post-delivery to encourage members to complete the postpartum visit between 3-8 weeks after delivery.

Providers are relied on heavily to make CalOptima aware of pregnant members. Providers are highly encouraged to submit a one-page pregnancy notification report (PNR) to CalOptima within seven days of the first prenatal visit, a measure CalOptima would like to improve. This partnership led to one of the program goals which is to improve coordination between CalOptima, contracted Bright Steps providers, county services and HN case management staff. Improving coordination with these entities should improve member care and experience during pregnancy.

MEASURES/RESULTS
The prenatal and postpartum care (PPC) HEDIS rates have been gradually trending upward. The following charts shows the HEDIS performance for the PPC measure in the past five years (2014-2018).

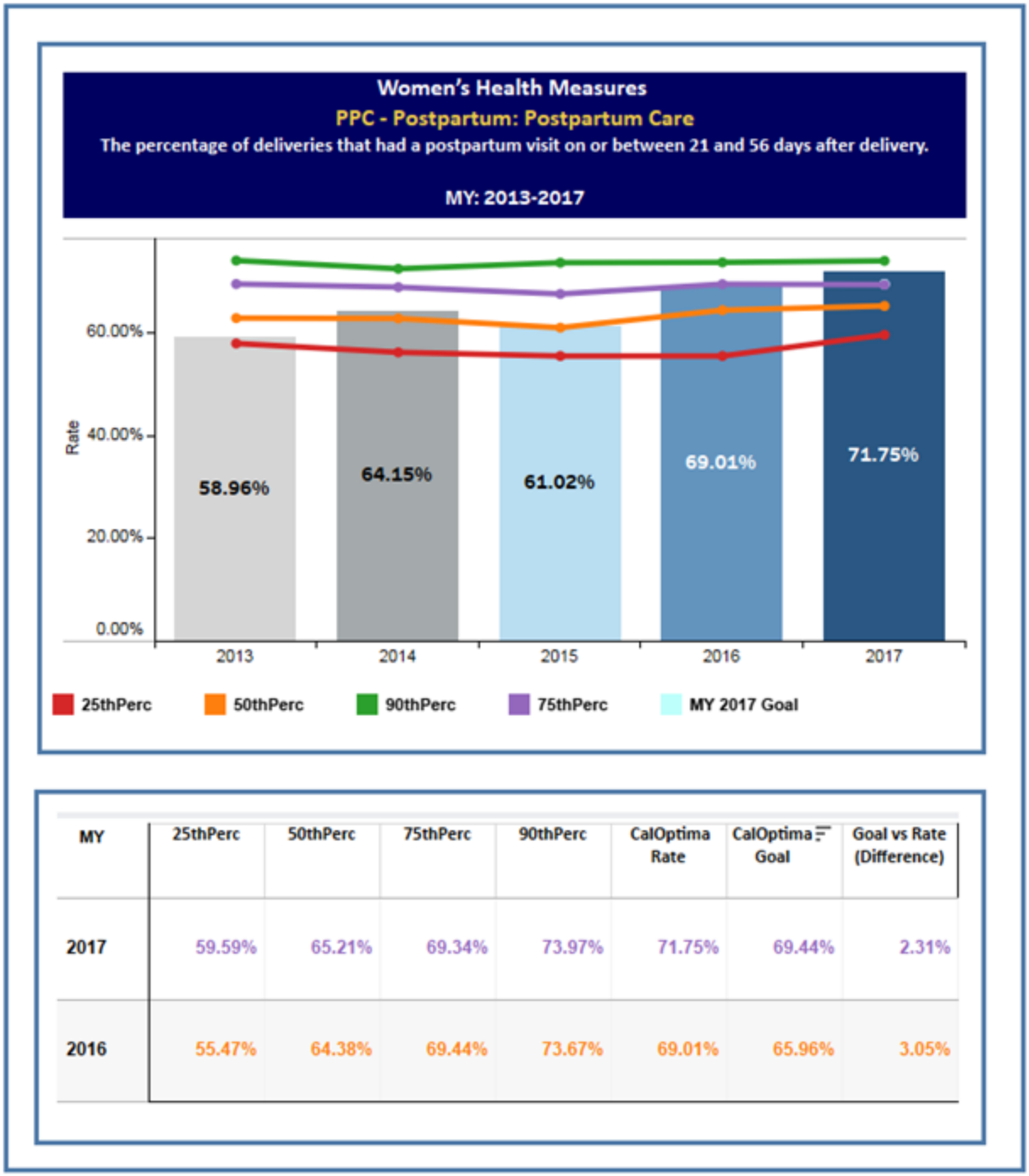
Prenatal and Postpartum Care (PPC) *Prenatal* sub-measure:



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	77.66%	83.21%	87.06%	90.75%	86.16%	86.79%	-0.63%
2016	74.21%	83.56%	88.59%	91.67%	84.98%	85.57%	-0.59%

The prenatal sub-measure has gradually been increasing the past three years but just shy of our targeted goal by less than 1% this year. However, CalOptima is currently at the 50th percentile of the 2017 NCQA quality compass. Implementing Bright Steps will assist in increasing this measure at future data points.

Prenatal and Postpartum Care (PPC) *Postpartum* sub-measure:



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	59.59%	65.21%	69.34%	73.97%	71.75%	69.44%	2.31%
2016	55.47%	64.38%	69.44%	73.67%	69.01%	65.96%	3.05%

The postpartum measure also has shown gradual improvements from HEDIS 2017 to HEDIS 2018. CalOptima has achieved the 75th percentile according to the 2017 NCQA Quality Compass and an improvement from last year. There has been many quality initiatives surrounding women's health and promoting postpartum care. CalOptima continued to work with our HN partners to promote postpartum health and conducted outreach to OBGYNs and CalOptima contracted CPSP providers.

November YTD reports show that the measure is trending a little lower when compared to the same time last year. However, we anticipate those rates will improve, as this measure is a hybrid measure and verification of postpartum visits are conducted through medical chart reviews.

Recommendations:

- To incorporate the member incentive program into the Bright Steps program. CalOptima Bright Steps will adapt a year-round approach for PCC measures, so the promotion of preventive screening and health check-ups are consistent and easy for the member and providers to access.
- Continue prenatal and postpartum packets but establish better data to determine pregnant members and their gestational age.
- Research if a provider incentive would be helpful to increase PPC rates. It is recommended that a pilot is completed to determine if a provider incentive increases PPC rates.
- Launch a Bright Steps media campaign so members, providers and other community partners are all aware of the program, benefits to CalOptima members, and ensure appropriate pregnancy care.
- Determine percentage of preterm deliveries and if determined high, plan and implement coordinating activities.

CHRONIC CONDITIONS

INTRODUCTION:

Aligning with CalOptima's strategic priorities, efforts have made to strengthen existing quality initiatives to engage CalOptima members with chronic conditions such as diabetes, asthma and cardiovascular disease. Addressing not only important tests and exams necessary for proper self-management of a chronic condition, activities and interventions focused on the whole person including necessary behavioral, mental, emotional and lifestyle factors which contribute or act as a barrier to achieving maximal health. CalOptima recognizes the complicated nature of living with a chronic illness and strives to assist our members with navigating their health with the best and most appropriate care and understanding as possible.

QI ACTIVITIES:

Clinical Practice Guidelines

CalOptima has adopted and adheres to the standards set forth by nationally acknowledged benchmark clinical practice guidelines for multiple conditions, examples below:

- National Asthma Education and Prevention Program (NAEPP) Guidelines for the Diagnosis and Management of Asthma 2007
- American Diabetes Association (ADA) Standards of Medical Care in Diabetes – 2017
- Nonpharmacologic Versus Pharmacologic Treatment of Adult Patients with Major Depressive Disorder: A Clinical Practice Guideline from the American College of Physicians

Disease Management (DM) Initiatives

Asthma — Adult Asthma Program Inclusion: In 2018, recognizing a growing population of CalOptima adults with asthma could benefit from DM management, the Asthma DM program identification methodology was expanded to include adults with asthma for all lines of business, Medi-Cal, OC and OCC. Historically, the Asthma DM program has been for the pediatric population, ages 3 to 18. However, with a significant number of adults identified with asthma, the adult population was added to help them manage their conditions with education and coaching. Newly identified adult members with asthma average between 300-400 members since the new methodology has been turned on in CalOptima Organizational Reporting Environment (CORE) reports. Of those members, approximately 47% are identified as having high acuity, qualifying them for telephone outreach by health coaches.

Medi-Cal Asthma Member Incentive: To encourage parents to take their children with asthma for an asthma visit, members with an Asthma Medication Ratio <50% were selected for a member incentive offer. The goal was for pediatric members to have an asthma visit with their PCP to obtain an updated Asthma Action Plan (AAP) along with long-term controller medications if needed. Members were then asked to return a copy of the AAP along with an incentive form to CalOptima to receive a $25 Target gift card. Of 1,127 members who were identified and sent the incentive offer, there was a lower than expected response rate at 3%.

Although preliminary on the impact of HEDIS 2018 measurement year rates, YTD rates as of November 2018 showed to be slightly below or around the 50th percentile compared to the prior year's rates. Impact analysis will not be available until final HEDIS rates for the measurement year are released.

Heart Health — Congestive Heart Failure: In 2018, cardiovascular health was addressed through the ongoing efforts of the congestive heart failure (CHF) DM program. The Heart Health newsletter was sent to all identified OC and OCC members with heart failure. Members showing high acuity were contacted by health coaches for telephonic sessions. In addition, the *OCC Heart Health Program Chronic Care Improvement Plan (CCIP)* concluded the three-year cycle by officially implementing the program.

- **Goal 1** of the CCIP was to obtain a 70% participation rate of identified OCC CCN with a primary discharge diagnosis of CHF in at least one session of the program.

- **Goal 2** was to reduce unplanned readmissions within 30 days for said identified members who participated in the OCC Heart Health Program.

  Barriers that delayed the implementation of this program were: identifying the correct data source for hospital discharges with date, time and discharge diagnoses; and long delays in collaboration with related department activities regarding transition of care with Case Management, UM and Pharmacy.

  However, by Q3, a pilot program began for CCN OCC members with a discharge diagnosis of CHF to be identified and contacted by a disease management health coach. All admissions for all primary diagnosis were considered for this program, as long as the CCN OCC member had a diagnosis of CHF. The aim was to prevent all hospitalizations

for CCN OCC members regardless of whether the primary diagnosis was CHF. All admissions/discharges from Anaheim Regional Medical Center and Fountain Valley Hospital were excluded due to a separate existing Transitions of Care (TOC) programs to avoid overlap. Despite challenges, the vetted program was adjusted, and program identification and outreach began in October 2018.

The program includes members being: 1) contacted telephonically and assessed by the health coach, 2) referred to the pharmacy department for medication reconciliation and consultation, and 3) maintained in DM health coaching for ongoing follow-up calls. Out of 9 unique members identified so far, 5 of the members were discharged to SNFs and therefore were not included in the program. Due to the late start of the program, formal evaluation has been postponed until the program has been running for a longer period. However, since October, of the 4 members identified as being discharged to home, 3 participated in the program, and 1 declined health coach sessions. Of the 4 eligible for the program, there have been no readmissions within 30 days. Of the 5 other identified admissions, those members were all in SNFs, experienced multiple readmissions within a 30-day period, and unfortunately 2 of the members expired during the review period.

Hypertension: In 2018, many members requested and received education from health educators or through mailings on how to control hypertension. In addition, CalOptima began a new *OC Improving Hypertension Management and Caregiver Involvement in OC Quality Improvement Plan (QIP)* which identified OC SNP members with a hypertension diagnosis. The QIP took a multi-prong approach to achieve several goals.

- **Goal 1** was to obtain 30% of PHI forms back for members. Through a previous QIP that addressed the same OC Hypertension population, health coaches came across the common barrier of not being able to speak with caregivers of members, due to the lack of a current Protected Health Information (PHI) form on file.

  A significant proportion of the OC SNP population have caregivers due to their special needs and require a current PHI to initiate any sharing of personal health information. As a lesson learned, members identified as requiring a PHI, were mailed a new PHI form to be returned. Not all such members did not necessarily have outdated PHI forms, but to eliminate barriers for health coach assistance by phone, the PHI forms were sent to caregivers, along with a caregiver guidebook for documenting all crucial information for their member. Additional interventions focused on improving member self-monitoring of their blood pressure. Members were offered a no-cost home blood pressure monitor if they committed to receiving ongoing telephone health coaching about medication adherence, lifestyle change and living with a chronic condition.

- **Goal 2** was to reach a 10% opt-in participation rate of members into the program.

- **Goal 3** was to show a decrease in blood pressure values of 20% among active participants in the program over their personal baseline. A total of 329 OC members with hypertension were sent a program offer. The program and blood pressure monitor opt-in offer along with information on medication adherence was received by 169 members with no PHI form on record. There were 160 members that showed having a PHI form

and were sent the program and blood pressure monitor opt-in offer as well as instructions on how to update their PHI form on file. The program participation rate was 2% n=7. Of the 7 participants who opted into the program, 4 members completed 3 health coach session. And 2 members completed 2 sessions and 1 member completed 1 session. Unfortunately, of the 160 members who were sent a PHI form, no forms were returned. This is in character with the unique barriers of outreach and interaction to the OC special needs population.

Diabetes — Identification Methodology Update**:** The Diabetes DM program made modifications to the identification methodology to exclude Type 1 diabetics from the current program. This may change as the California Children's Services population transitions in through the Whole-Child Model.

Medi-Cal Diabetes A1C Testing and Eye Exam Member Incentives: The member incentive program for adult Type 2 diabetics who needed an A1C test or Eye Exam, continued in 2018. The goal was to impact HEDIS Comprehensive Diabetes Care measures for A1C testing and Eye Exam by encouraging members who had not had a test or exam in 2018 to get their A1C test or eye exam completed. Of the 10,892 members identified and offered the A1C testing incentive, 535 forms were received with a response rate of 4.9%, consistent with former year response rates. Of the 15,696 members identified and offered the Eye Exam incentive, 541 forms were received, with a response rate of 3.4%. The incentive continued until December 31, 2018, when the offer was closed. Although the impact on the CDC measures will not be known until final HEDIS rates are published, prospective rates as of October 2018 showed 83.12% for A1C testing and 52.08% both an increase over October 2017 rates last year.

Diabetes Improvement Plans: There were multiple initiatives executed in 2018, that aimed to affect change by moving testing and compliance rates through targeted interventions and outreach.

CCN Diabetes Initiative: According to CalOptima's HEDIS 2017 (MY 2016) data, there was a total of 28,542 CalOptima members 18–75 years of age who have been diagnosed with diabetes, with 11,747 (41.16%) who had poor or uncontrolled diabetes (HbA1c >9.0%). CalOptima's June administrative prospective (HEDIS 2018) rates show 26,281 members 18–75 years of age have been identified with diabetes and 15,636 (59.50%) have poor or uncontrolled diabetes. This sub-measure rate is currently below the 25th percentile of the HEDIS Quality Compass. Therefore, CalOptima focused our efforts in 2018 on targeting our CCN to reduce the number of members with poor or uncontrolled diabetes. An internal workgroup composed of various departments (Medical Affairs, Quality Analytics, Health Education/Disease Management, Case Management and Pharmacy) was tasked to develop a multi-prong approach in addressing the barriers surrounding the poor or uncontrolled population. To address the poor or uncontrolled diabetic population 15 CCN high-volume provider offices were targeted.

The medical directors along with Health Education/Disease Management and Quality Analytics staff conducted in-person outreach to the 15 targeted offices and their medical directors and staff. CalOptima provided offices their member data, CalOptima resources (educational materials and disease management and case management referrals), and opportunities for collaborating to improve member health outcomes.

MEDI-CAL PERFORMANCE IMPROVEMENT PROJECTS (PIP)

Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c>9%) This year, CalOptima started a new PIP as directed by the DHCS to focus on health disparities. CalOptima chose to focus on the geographical area disparity in Orange County that impacts Medi-Cal members with diabetes. It was aligned with a diabetes initiative that the plan was focusing on to improve the rates for poor or uncontrolled diabetes. After comparing rates among these cities, Santa Ana was identified as the city with the greatest number and rate of CalOptima Medi-Cal members with poor or un-controlled HbA1c levels (44.33%). Garden Grove (36.78%) was used as a comparison group to assess the disparity.

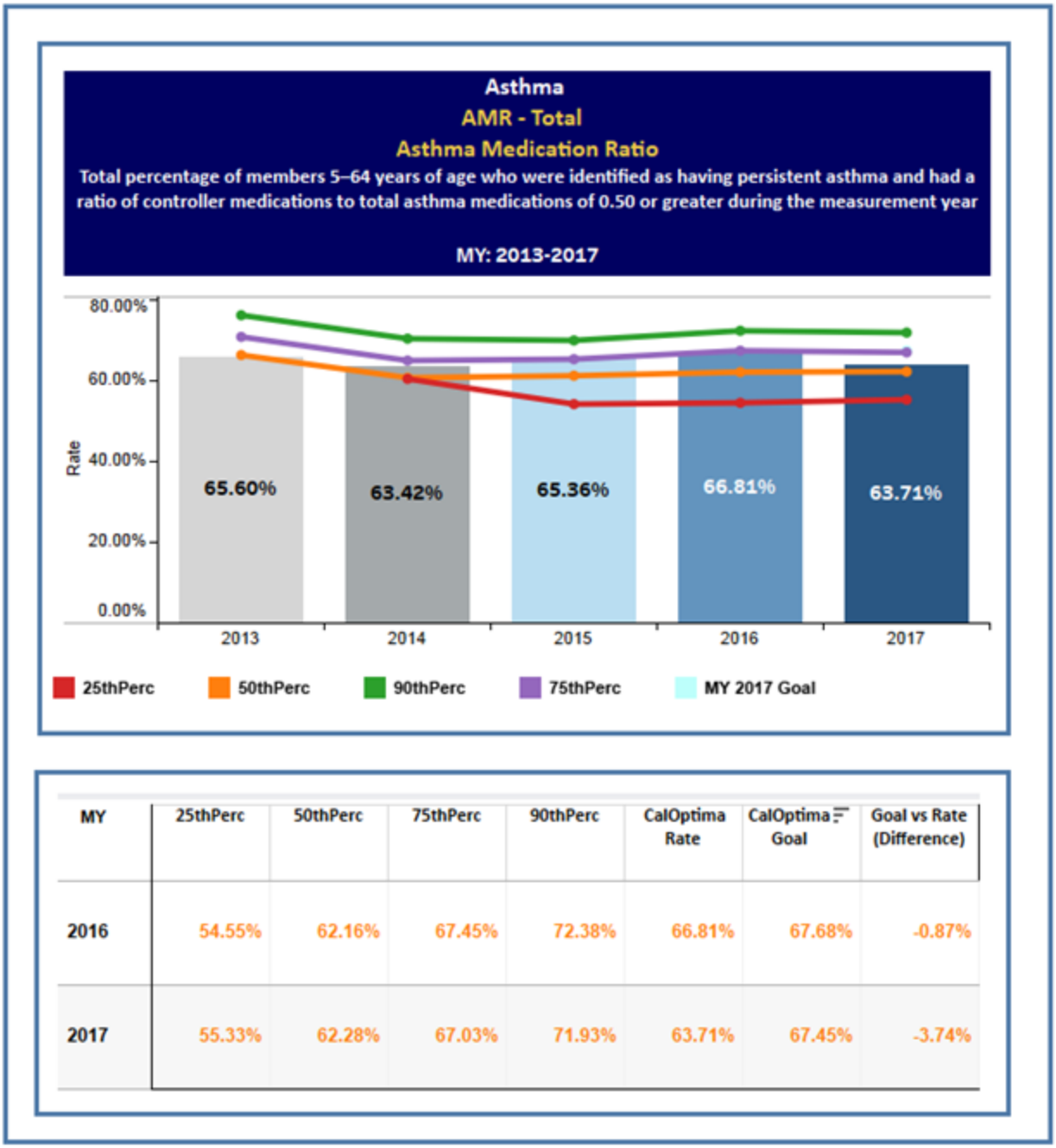
Within the city of Santa Ana, the Hispanic population has one of the highest rates of poor and un-controlled HbA1c levels >9.0% (n=1,446, 45.64%). Further narrowing the target population for this PIP, CalOptima focused in on HN providers within the city of Santa Ana. All 14 of CalOptima's contracted HNs provide care for Medi-Cal diabetics within the city of Santa Ana. Among these HNs, CalOptima CCN serves the highest volume of diabetics (n=956, 17.15%). Furthermore, there are 176 providers and clinics contracted with CCN, with 14 offices that are high-volume. High-volume was defined as providers or clinics serving 10 or more diabetic CCN members in Santa Ana during measurement year 2016. These 14 high-volume offices account for 440 diabetic members (46.71%) with 224 of those members having poor or uncontrolled diabetes (38.75%) within Santa Ana's CCN population.

CalOptima will be conducting two interventions for this PIP project which includes: 1) health coach outreach to the two targeted provider offices in the CCN network, and 2) provider office staff outreach to members to promote HbA1c testing and educate members on the importance of diabetes management during the office visit.

OC Diabetes A1C Testing Chronic Care Improvement Plan (CCIP)
In 2018, a pre-established OC Diabetes A1C Testing QIP was transitioned into a CCIP for the last year of the 3-year plan cycle per CMS. Goal 1 was to impact HEDIS OC A1C testing rates by raising the rate to 93.90%, an increase of 1.88% over the baseline of 92.02% from HEDIS 2015 final rate. Intervention strategy changed from previous years from member-focused mailings to telephonic outreach by disease management health coaches. Goal 2 was to obtain a 50% confirmation rate obtaining verification of a completed A1C test for 2018 from the identified contact. Health coaches trained in motivational interviewing skills were provided a list of N=111 members with no A1C test on record as of August 2018. Health coaches would initiate outreach calls with two attempts, before determining members were unable to contact (UTC) and sent a UTC letter. Those members who were reached were engaged in a coaching session and members were encouraged to get A1C testing done if they had none on record. Through the intervention process, health coaches identified missing A1C testing information either by obtaining it directly from members, from providers and finding data in the Aerial/Cerecons data repository. They also identified members who were no longer eligible.

TRENDING RATES AND RESULTS

Asthma Medication Ratio



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016	54.55%	62.16%	67.45%	72.38%	66.81%	67.68%	-0.87%
2017	55.33%	62.28%	67.03%	71.93%	63.71%	67.45%	-3.74%

The AMR rates have slightly decreased from last year but CalOptima remains at the 50th percentile of the NCQA Quality Compass benchmarks.

Congestive Heart Failure CCIP

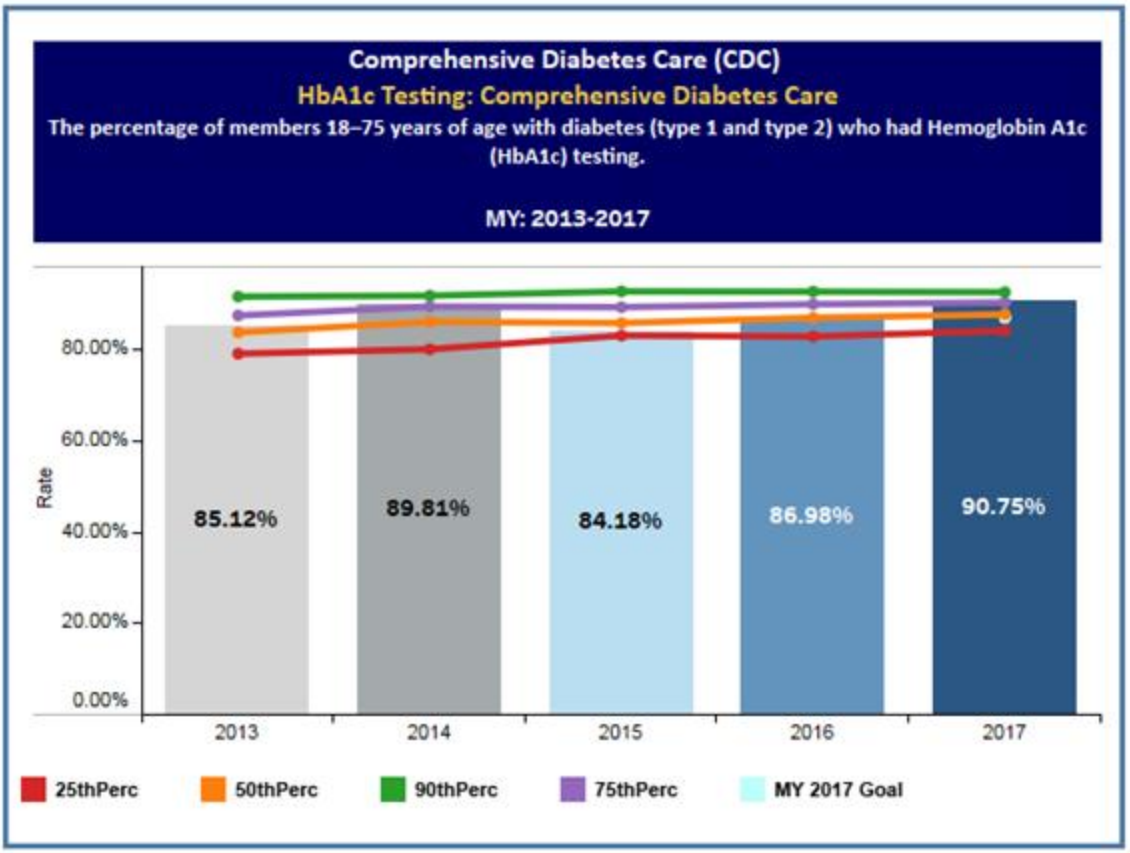
OCC CCN CCIP

OCC CCN CHF UNPLANNED READMISSION CCIP 2018	
BASELINE DATA - October 1, 2017 – September 30, 2018	TOTAL

CCN OCC Members with CHF	122
CCN OCC Admits All DX with CHF Flag*	56 (46 unique members)
CCN OCC Re-Admits All DX with CHF flag within 30 days with CHF Flag*	29 (13 unique members)
CCN OCC Admits with Primary DX of CHF *	3 (3 unique members)
CCN OCC Re-Admits Primary DX CHF within 30 days with CHF Flag*	1 (1 unique member)

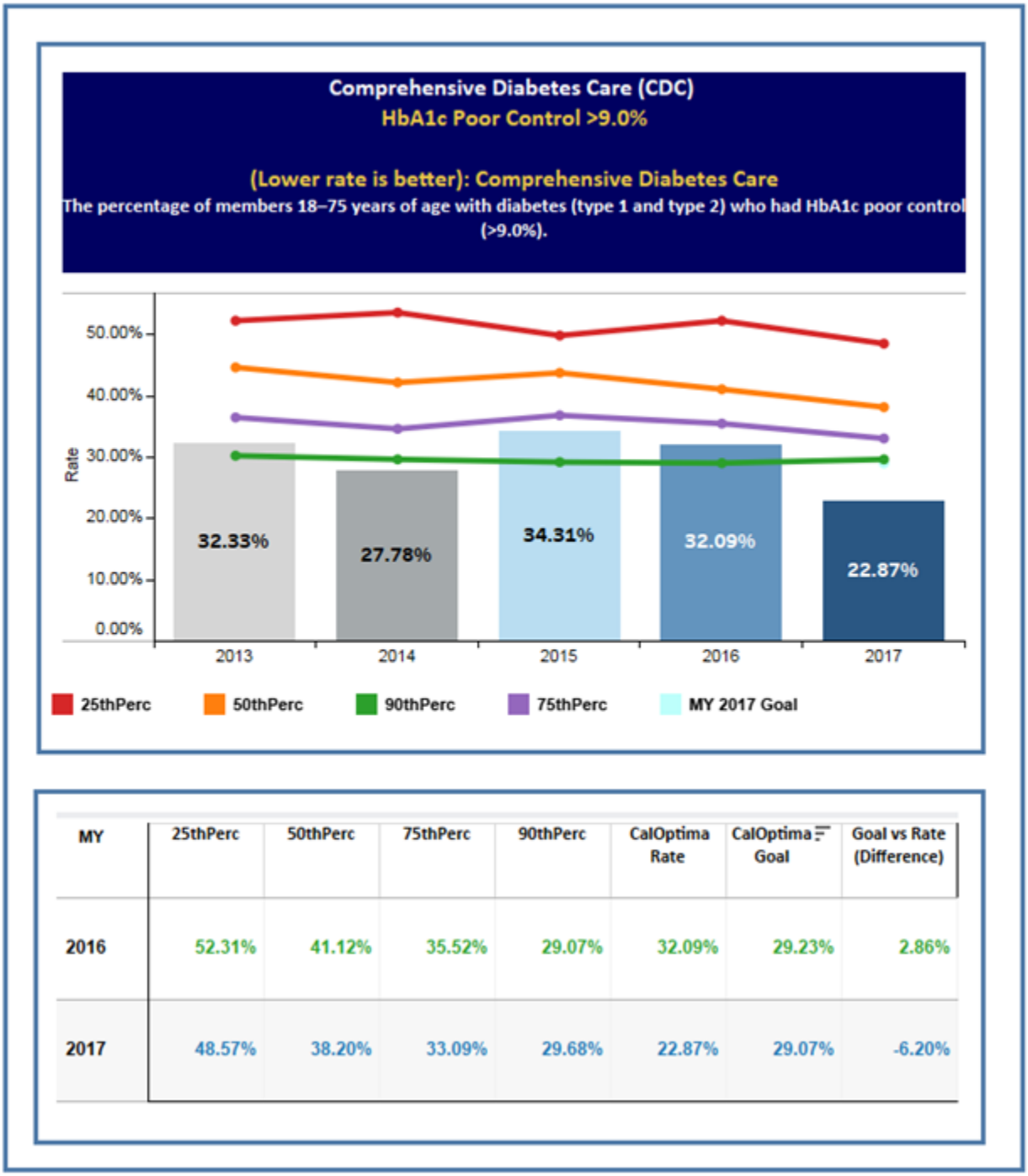
*Excludes: Anaheim Regional Medical Center and Fountain Valley Hospital Admissions and Readmissions. Includes members in SNFs. All long-term care residents were excluded from these counts.

Comprehensive Diabetes Care (CDC)



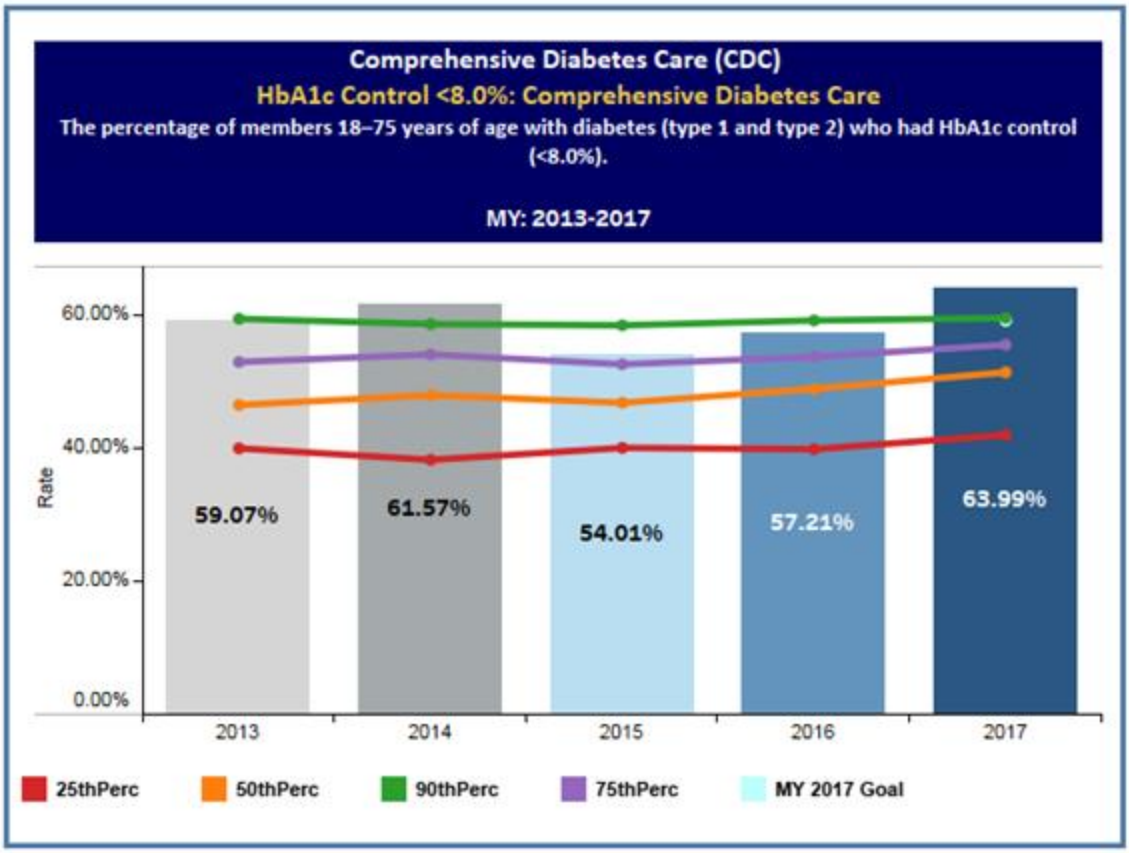
MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016	82.98%	87.10%	90.06%	92.82%	86.98%	88.08%	-1.10%
2017	84.25%	87.83%	90.45%	92.70%	90.75%	87.10%	3.65%

CalOptima met goals for HEDIS 2018 (MY 2017) and achieved the 75th percentile of the NCQA Quality Compass benchmarks. The HbA1c testing sub-measure is incentivized through the P4V program.



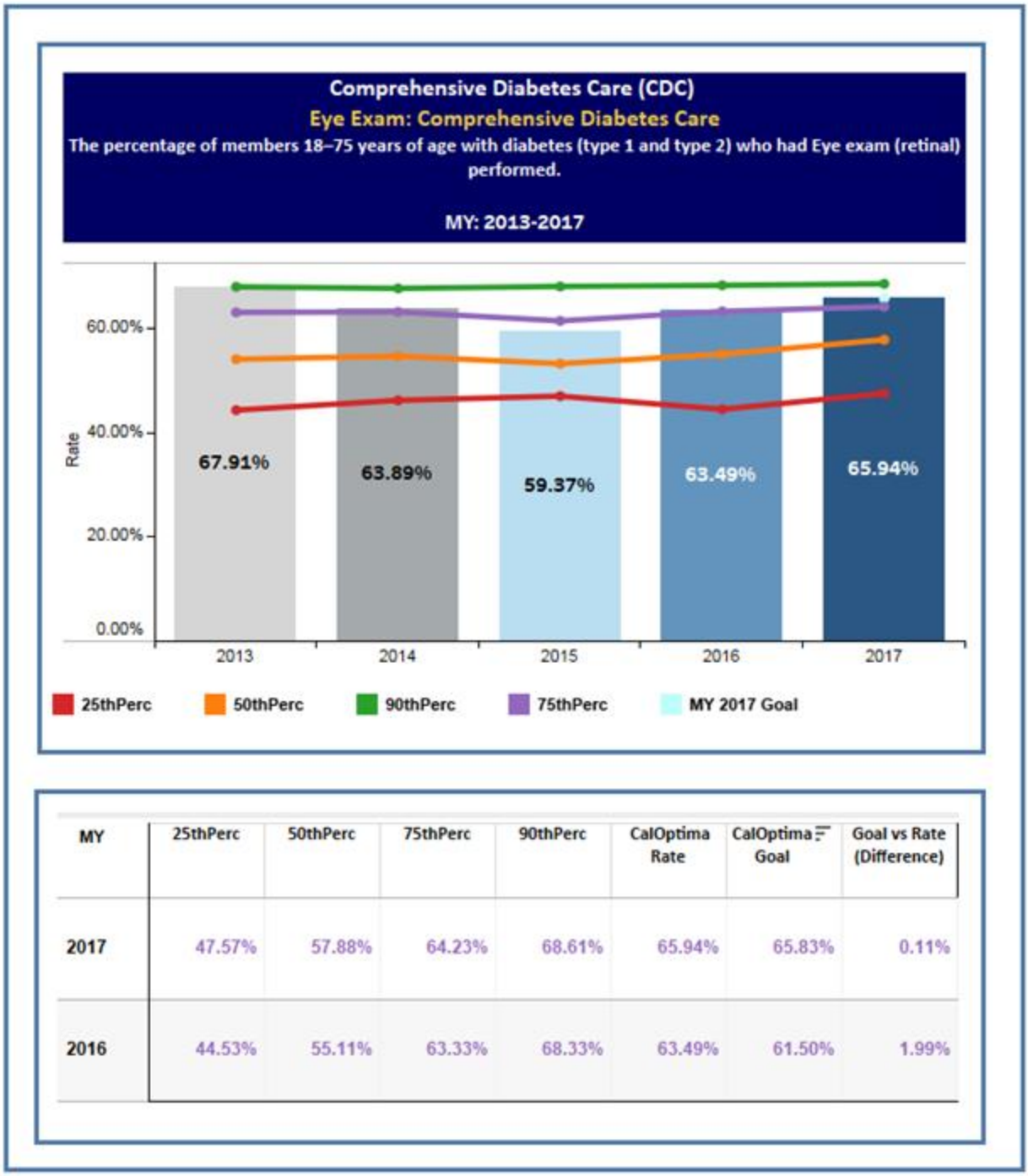
MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2016	52.31%	41.12%	35.52%	29.07%	32.09%	29.23%	2.86%
2017	48.57%	38.20%	33.09%	29.68%	22.87%	29.07%	-6.20%

CalOptima has shown great improvements for the CDC poor control (>9) sub-measure and rates has dropped by 10 percentage points from MY 2016. Lower rates mean better performance for this sub-measure. There was a statistically significant changed from last year and CalOptima has achieved the 90th percentile of the NCQA Quality Compass benchmarks.



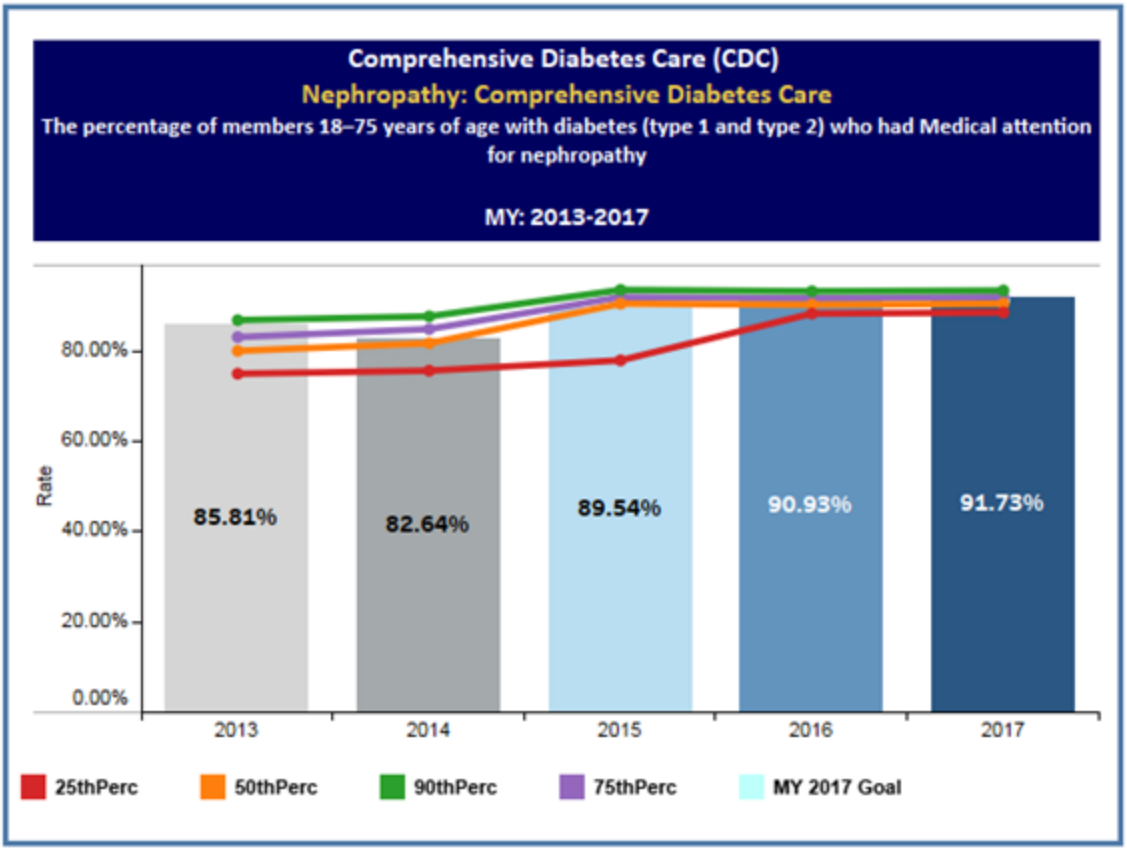
MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	41.94%	51.34%	55.47%	59.49%	63.99%	59.12%	4.87%
2016	39.80%	48.87%	53.65%	59.12%	57.21%	55.47%	1.74%

The CDC HbA1c Control (<8.0%) sub-measure has gradually increased in the past three years. CalOptima met our goal and has achieved the 90th percentile of the NCQA Quality Compass benchmark for this sub-measure. Furthermore, this is a statistically significant improvement compared to last year.



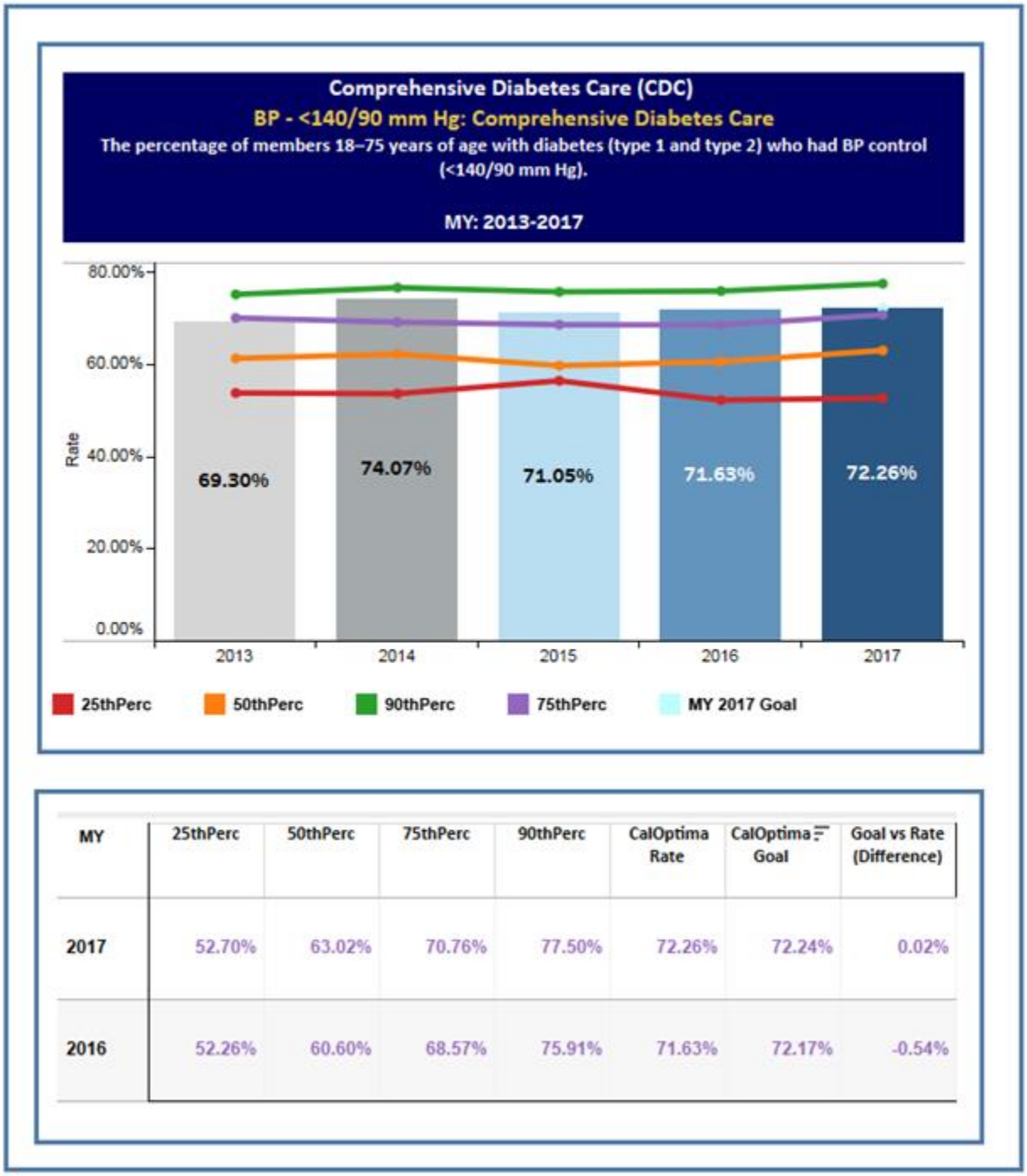
MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	47.57%	57.88%	64.23%	68.61%	65.94%	65.83%	0.11%
2016	44.53%	55.11%	63.33%	68.33%	63.49%	61.50%	1.99%

The CDC Eye Exam sub-measure has gradually increased in the past three years. CalOptima met our goal and has achieved the 75th percentile of the NCQA Quality Compass benchmark for this sub-measure. This measure is also incentivized through the P4V program.



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	88.56%	90.51%	92.05%	93.43%	91.73%	91.24%	0.49%
2016	88.32%	90.27%	91.67%	93.27%	90.93%	91.20%	-0.27%

The CDC Nephropathy sub-measure has steadily remained the same for the past three years. The benchmarks for each percentile have been very close. CalOptima currently stands at the 50th percentile of the NCQA Quality Compass benchmarks. We will continue our efforts in improving this sub-measure for next year.



MY	25thPerc	50thPerc	75thPerc	90thPerc	CalOptima Rate	CalOptima Goal	Goal vs Rate (Difference)
2017	52.70%	63.02%	70.76%	77.50%	72.26%	72.24%	0.02%
2016	52.26%	60.60%	68.57%	75.91%	71.63%	72.17%	-0.54%

The CDC Blood Pressure (<140/90mm Hg) sub-measure has slightly increased from last year and remains at the 75th percentile of the NCQA Quality Compass benchmarks.

COMPREHENSIVE DIABETES CARE (CDC) PROSPECTIVE RATES				
Measure	**2018 Goal**	**2018 Final Rate**	**Met/Not Met Goal**	**Percentile**
HcA1c Testing	87.10%	90.75%	Met	75th

HbA1c Poor Control (>9.0%) *Lower rate is better	29.07%	22.87%*	Met	90th
HbA1c Adequate control (<8.0%)	59.12%	63.99%*	Met	90th
Eye Exam	65.83%	65.94%	Met	75th
Nephropathy Monitoring	91.24%	91.73%	Met	75th
B/P <140/90	72.24%	72.26%	Met	75th

* Indicates a statistically significant change

With the high focus on Diabetes this year, CalOptima has achieved between the 50th and 90th percentile for the CDC measures. The sub-measures have been trending upward and moving in the right direction.

MEDI-CAL PERFORMANCE IMPROVEMENT PROJECTS (PIP)

Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c>9%)
The Medi-Cal PIP data collection is in process and therefore there is no data that can be reported at this time.

OC Diabetes Chronic Care Improvement Project (CCIP) to Improve HbA1c Testing

OC DIABETES A1C TESTING CCIP	
Identified Call List N=111	TOTAL
Call Success Rate to members	36% (N=40)
Number of A1C Tests Confirmed as already complete during outreach	54
A1C Testing confirmed in Aerial/Cerecons	24
Members enrolled in Diabetes DM program through calls	10

Of the 111 identified members missing an A1C test as of August 2018, 54 members were identified as already having an A1C already completed, either identified from a member lab report, provider confirmation or evidence in the Aerial/Cerecons data repository. A disconnect or lag in lab data may account for 48% of the list not showing labs completed as up-to-date.

NEXT STEPS:
With the transition to a population health management approach and strategy of program planning, the emphasis will be shifting to address connecting and engaging the larger population with messages about being proactive about taking control of their chronic conditions. The hope is that communication and member engagement will improve and expand with the adoption of broader technological modes of interaction, such as texting and telehealth.

Asthma: Newly identified asthma adult members will be sent a new DM member packet to

introduce them to asthma self-management and tools available to them at no-cost. The member asthma incentive will be renewed for 2019, however in lieu of an asthma action plan, an Asthma Control Test will be included to be completed and returned to assess whether members asthma symptoms are well controlled. For those showing risk of uncontrolled asthma, health coaches will reach out to provide guidance on medication adherence and preventing exposure to triggers.

Heart Health: *Congestive Heart Failure* — The CHF post-discharge program will continue post-hospital discharge to guide members with CHF through navigating transition of care successful and hopefully make an impact in reducing unplanned readmissions within 30 days due to uncontrolled symptoms or lack of medication adherence. Due to barriers (i.e. data, system, and low numbers) during the planning stage, the full intervention did not start until Q4 calendar year. Although the CCIP reporting period for this measure ends 12/31/2018, CalOptima will continue to provide interventions into 1Q of next year and re-evaluate the merit of program continuation at that time.

Hypertension: Hypertension control and self-blood pressure monitoring program was discontinued due to low response from the OC population. Due to the high percentage of members with special needs or permanent disability, the OC population continues to prove to be challenging in terms of participation rates and responsiveness.

Diabetes: With the integration of the California Children's Services population into CalOptima, there is anticipation that Type 1 diabetics may potentially become incorporated into the DM programs. In anticipation, continuing education and training events are being considered for staff to broaden their knowledge base and be prepared to sufficiently address future member needs.

CalOptima will continue the outreach efforts for the CCN Diabetes initiative through the end of 2019. In addition, the Medi-Cal PIP project targeting will run through the end of June 2019. The status of the PIP project will be submitted to DHCS.

SUMMARY:

There are many opportunities to take in improving member interaction, member experience and impacting health outcomes for CalOptima members with chronic illnesses. Using the data and analysis made available recently through Tableau, the hope is to be strategic in identifying and planning far-reaching and impactful programs and interventions in 2019. There are opportunities to engage both members and providers in a team approach towards achieving optimal health outcomes for our members. The Health Management and QI collaboration with other areas in this endeavor promises a challenging yet more cohesive plan that will hopefully benefit our member population.

COORDINATION OF CARE

INTRODUCTION:

Navigating the health care system can be a challenging experience, particularly for members with chronic health conditions or complex health care needs. Furthermore, some Medi-Cal

benefits (e.g. specialty mental health services) are carved out from the managed care plan which makes it difficult to coordinate care. Effective care coordination ensures members receive care in a safe, effective, member centered, timely and efficient manner. CalOptima's care coordination activities include but are not limited to organizing member care activities, sharing information among the health care participants concerned with member's care, and achieving safer and more effective care. The main goal for care coordination is to meet members' needs and preferences in the delivery of high-quality, high-value health care.

QI ACTIVITIES:

The following describes some of the ongoing quality intervention activities which have occurred over the past year. Activities are chosen by the department as an opportunity for improvement, a new intervention for an area that is starting to show decline in results, or a new innovative idea or program to address a special focus or population.

ICT Participation – Behavioral Health Services
Interdisciplinary Care Team (ICT) meetings are offered to members that qualify as Seniors and Persons with Disabilities (SPD). During ICTs, all providers involved in a member's care are invited to provide updates and participate in developing an Interdisciplinary Care Plan (ICP) that is beneficial to and inclusive of the member's care needs. A behavioral health (BH) clinician attempts to contact the provider, where indicated, to extend invitation to participate in ICT meetings and /or complete ICPs. ICTs are initiated for members that fall into a selective category as defined by the CalOptima Model of Care. Once an ICT is set up for a member and behavioral health services are deemed appropriate, the team connects with the BH clinician to start the invitation process. The BH clinician attends all ICT meetings where BH is indicated for CCN and OCC members. A measurement of success is when BH services are indicated and the clinician is successful in having the treating provider participate in the ICT. Another successful measure is to have the information completed in the member ICP with the treating providers intent for treatment and member collaboration.

Follow Up After Hospitalization for Mental Illness
This is a quality initiative and HEDIS measure that the BHI department has been monitoring since its inception. The intent of this measure is to ensure that a member has an appointment for a follow up care visit with a clinical provider within 7 and 30 days of discharge from the hospital. As a former OC and active OCC initiative, this population is managed by CalOptima's MBHO. The behavioral health clinical team discusses strategy and interventions with the MBHO monthly. Concurrently, the BHQI work group monitors the HEDIS rates and supplies a report to the MBHO to ensure that our system is accurately collecting the data representative of the population that the MBHO is working with to secure follow up care. Active intervention includes MBHO actively following all levels of cases (members) hospitalized through the discharge planning process and makes several attempts to contact members with appointment reminders and assistance with provider linkage. The measurement of success for this activity is follow-up visits for all members within the 7 and 30-day timeframes for persons discharged from the hospital for care for a mental health diagnosis. HEDIS sets benchmarks annually that are used as indicators on a national level. CalOptima sets goals to align with the national standard.

Emergency Department Utilization for Behavioral Health Services

Using guidance from CMS, CalOptima measures the total number of Emergency Department (ED) visits for members in OCC with a principal diagnosis related to behavioral health (OCC Core 9.1). Claims submitted for services rendered in an ED with specifiers for a BH diagnosis are tracked and trended. At this time the claims data is reported quarterly to CMS and compared to all CCI plans in California. Internally, the BH team reviews the data for trends i.e. access to services on weekends, with the goal to reduce use of ED for routine service needs. Findings are shared with County Behavioral Health and the MBHO to determine best practices to coordinate routine care, avoiding ED use whenever possible. CMS implemented this measure and needed to establish a baseline and has now implemented a goal of 56% utilization rates.

OCC CA 1.7. Coordination of Care with County Mental Health
Measures the coordinated care efforts between the County mental health system and CalOptima for members receiving specialty mental health services for three consecutive months or more. This is a CMS quality activity where a baseline is being determined for future goal. So far, this has been reported once, on an annual basis. Metrics for this measure focus on locating eligible members and making phone calls to the provider and the member to ensure they are receiving care coordination with the primary mental health provider. Behavioral health pulled records using a blend of pharmacy and county claims to determine the eligible member set that would receive phone calls. Each member and provider will receive a maximum of three phone calls in attempt to confirm they were seen for services. Reporting considers successful and unsuccessful outreach attempts and is captured for submission to CMS. The goal of this measure is to ensure that members are receiving additional supports in their health care plan that can truly improve their well-being.

CalOptima Nurse Care Managers (NCM's) Program
CalOptima's PDSA project with CMS proposes for CalOptima NCMs to provide enhanced onsite care management support to OCC members residing in nursing facilities with recent histories of acute admissions. The purpose of these interventions will be to increase post-hospitalization support, in coordination with the nursing facility staff, to lower outstanding or developing risks and subsequently decrease acute readmission rates.

OCC QIP to Improve 30-day Readmission Rate (Year 3)
This is the third and final year that CalOptima will be working on the QI project focusing on improving 30-day readmission rates for OCC members. This QIP project targets OCC members admitted to either Fountain Valley Regional Hospital or Anaheim Regional Medical Center with any diagnosis (excluding pregnancy and severe mental health). Members are outreached by a health coach to receive home visits and follow-ups after discharge as part of the Transition of Care (TOC) program. After initial contact with a health coach, a member may be ineligible for the TOC program based on the following criteria;

- Enrolled in MSSP or Program of All-Inclusive Care for the Elderly) PACE program
- Enrolled in Long-Term Care
- Enrolled in hospice
- With developmental disabilities or dementia without caregiver support
- With significant behavioral health issues
- With admit the same day as discharge
- With admits resulting in death

- Enrolled in California Children's Services
- Homeless

For this TOC program, members are offered in-person and telephonic health coaching services to help reduce their chances of readmission. The program promotes self-management and awareness about improving their health outcomes. The health coaches review member's medical record, conduct medication assessment and provides coaching to help the member and their care takers manage their health better to reduce readmissions to the hospital.

OCC Performance Improvement Project to improve CA 1.5 and 1.6
In 2018, the Centers for Medicare and Medicaid Services (CMS) requires that CalOptima participate in at least two performance improvement projects annually. This year, the PIP topic was determined by the State and assigned to CalOptima. The topic is based on two California-specific reporting measures: CA 1.5 – Members with an Individualized Care Plan Completed and CA 1.6 – Members with Documented Discussions of Care Goals.

CA 1.5 measures the completion of an ICP. ICPs improve member health, functional status, and satisfaction by incorporating the member's goals and preferences into a comprehensive plan to address the member's unmet needs. It leverages the member's responses to a health risk assessment and promotes self-determination and communication between the member and the care team by ensuring the member's voice is present in the care planning process. Furthermore, the member's engagement in the process promotes self-care.

CA 1.6 is closely linked to CA 1.5 as the discussion of the member's care goals is vital to engaging the member in the ICP. These discussions allow for strategizing and planning interventions to meet the care goals established by the member and team. The ICP consists of individualized care goals developed by the ICT. The ICT includes the member, caregiver, PCP, specialists, and other providers involved in the member's care. The ICP documents and prioritizes the individualized care goals based on the member's preferences and readiness for change. The individualized care goals are periodically re-evaluated with the member and revised based on the member's current health care needs, desires and functional abilities. A self-management plan developed with the member is inherent in every ICP.

Because the ICP and individualized care goals are developed in collaboration with the member, they reflect the member's desires and commitment to achieve his or her health care goals. Each time the member discusses his or her goals with a member of the care team, he or she further commits to completing the actions necessary to achieve those goals. This collaboration increases member engagement in the care planning process, and therefore, increases the likelihood of positive health outcomes.

TRENDING OF MEASURES/RESULTS:

ICT participation
BH continues to see increase in the participation rates of behavioral health providers. This year a goal of 95% provider participation was implemented. Last year, the goal was to achieve a 10% improvement in participation over the previous years' participation rate. Measuring participation in ICTs has evolved several times since its inception. In 2017, we refined the definition of

participation and revised the formula used for calculation of participation. As the delegated entity, the MBHO was responsible for participation for the CCN membership during that year. ***Reporting looks somewhat different since the calculation and definition changed from 2017 to 2018.*** ICT participation under the delegated model ranged from 91% to 100% quarterly.

2017	Q1 Total		Q2 Total		Q3 Total		Q4 Total	
	I	P	I	P	I	P	I	P
	17	17	20	18	14	14	24	24

2018	Q1 Total		Q2 Total		Q3 Total		Q4 Total	
	I	P	I	P	I	P	I	P
	9	4	43	26	33	23		

The rates for 2017 do not accurately report a comparison opportunity since the formula for calculation was adjusted for a more accurate representation of the activity being captured. For 2018 rates we refined the definition once more. Between Q1 and Q2 there was an adjustment made to the participation definition, impacting the goal. However, between Q2 and Q3, there was continued improvement and we are closing Q4 soon. Overall, the department is happy with the success.

Follow Up After Hospitalization for Mental Illness
The Follow Up After Hospitalization for Mental Illness (FUH) HEDIS measure focused on the OC /OCC services has been monitored by BHI since 2013. This is a delegated activity that is handled by our MBHO. Traditionally, rates were reported for OC and OCC populations, but have since been transitioned to reporting for OCC exclusively due to the 30-claim count requirement. For 2018, OCC Goals were: 52.40% and 31.21%; and neither goal was met. BHI monitors and addresses progress where needed. A 30-day and 7- day follow up appointment rate is measured.

Emergency Department Utilization for Behavioral Health Services
This is a quarterly report based on claims for services in the ED for members with a primary diagnosis of BH. Coordination with County and the MBHO for members visits has been essential to ensuring that members receive care needed in the appropriate care setting. A challenge with this measure has been the lack 24-hour walk in clinics in OC with the ED being a last resort treatment site for some members. Most recent quarter demonstrated reduction in ED use. Q1: 93, Q2: 103, Q3: 76. Q4 will be reported for in 2019.

Core 9.1 is reported to CMS quarterly with comparisons to the California CCI plans each cycle. CalOptima started at a very high rate of members using the ED for services. Over the two and a half year reporting cycle, there has been a continuous decline in the use of ED for behavioral health services which is the goal we hoped to achieve. The results are intended to capture the number of members that are being seen for services in the ED and to discourage those members

from using the ED for services that can be provided in the outpatient clinic. We are also seeking to understand if there are gaps in service hours or needs that require members to seek services at the ED as a first response. Below is a snap shot of Q2 for 2018.

Core 9.1 Emergency Room Behavioral Health Services Utilization

Table 3. Emergency Room Behavioral Health Services Utilization

MMP Name	Number of Behavioral Health-Related ED Visits with a CPT or UB Revenue Code for an ED Visit and a Principal Diagnosis Related to Behavioral Health per 10,000 Member Months (Q2 2018)
CalOptima	22.99
Plan B	13.54
Plan C	11.57
Plan D	36.05
Plan E	10.28
Plan F	35.09
Plan G	20.33
Plan H	25.90
Plan I	13.44
Plan J	25.35
CA Average	21.45
CA 90% Interval for Detecting Outliers	6.86–36.05

Notes: For measures reported as a percentage, the interval for detecting outliers is bounded by 0.0% and 100.0%; for all other measures, the lower bound for the interval for detecting outliers is bounded by zero. Statewide averages are not enrollment weighted averages.

OCC CA 1.7. Coordination of Care with County Mental Health

This was the first reporting cycle for this measure. There was no benchmark or goal to meet for this first attempt. Success was measured by outreach attempts and by completing the activity for the measurement period. The 2018 reporting cycle is being completed at this time for reporting due in April of 2019.

CA 1.7 Reporting 2017	
Total number of members receiving Medi-Cal specialty mental health services	
A	122
Total number of member's providers unable to reach on 3 attempts for care coordination	
B	1; With 76 providers receiving only 1 or 2 attempts and 4 with no attempt
Total number of successful MMP contacts with county mental health provider for care coordination	

C	41
Total number of member's MMP unable to reach on 3 attempts for care coordination	
D	20; with 13 members receiving 1 or 2 attempts; 16 members no outreach made
Total number of members MMP successfully contacted for care coordination	
E	67; with 6 additional members reached but declined to participate

CalOptima Nurse Care Managers (NCM's) program
Enhanced care management strategies for the targeted OCC CCN LTC members can involve the following interventions, as appropriate:

- Field visits with members
- Increased contact with member/family member(s)
- Increased coordination with facility staff
- Increased participation in ICT meetings at the facility
- Pharmacy consult post-discharge
- Education and training with member/family member(s)
- Support in completing an advance directive
- Structured motivational interviewing/goal setting with members
- Additional coordination with ICT members, including the PCP

The assigned CalOptima NCM will be primarily responsible for either directly completing or supporting the facility staff's completion of the interventions outlined above, as appropriate. If a need for any of these interventions is identified, the NCM will attempt to ensure it is initiated within 30 days of contacting the member/family member.

While the assigned NCM will provide their availability to the member/family member and facility staff, the CalOptima PCCs, with their consistent availability in the office, will also act as additional contact points for the member/family members. The PCC can also follow up on referrals and meetings, as needed.

OCC QIP to Improve 30-day Readmission Rate (Year 3)
Preliminary results for the 2018 show the following:

Eligible members who received COACHING		**Numerator**	**Denominator**	**Percent**
	Readmission	0	2	0%
	No Readmission	2	2	100%

Eligible members who DID NOT		**Numerator**	**Denominator**	**Percent**

receive COACHING				
	Readmission	1	16	6.3%
	No Readmission	15	16	93.8%

Eligible members who received COACHING	Who conducted a follow-up visit?	Numerator	Denominator	Percent
	Follow-up	1	2	50%
	No follow-up	1	2	50%

Eligible members who DID NOT receive COACHING	Who conducted a follow-up visit?	Numerator	Denominator	Percent
	Follow-up	0	16	0%
	No follow-up	16	16	100%

The OCC QIP has a show a very small sample size of 18 members eligible for the OCC CNN TOC program. This is due to the fact that CalOptima had a narrowed focus on the OCC CCN members who had an admission to the two participating hospitals (Fountain Valley Hospital and Anaheim Regional Medical Center).

Preliminary results show 2 of 18 eligible members chose to participate in the TOC program. There were no readmissions (100%) within 30 days for those 2 members. Of those who received coaching, only 1 (50%) followed up with a PCP or specialist after their hospitalization. For the no coaching population, there were 16 members in the denominator and only one readmission (6.3%). There were no follow up visits with a PCP post-hospitalization for the no coaching group.

CalOptima experienced staffing changes during the year due to competing priorities. However, new staff was brought onboard to continue the efforts in outreach. This change brought the opportunity to revisit the program and assess opportunities for improvement. The case managers were able to update some of the internal processes to streamline the efforts. In addition, the TOC program is open to the Medi-Cal population as well and the health coaches are outreaching for that population too.

OCC Performance Improvement Project to Improve CA 1.5 and 1.6
In the following table for Study Indicators 1 and 2 (based on CA 1.5), specifies the title of the study indicator, the goal CalOptima is attempting to achieve, the reporting period for this progress update, and the interim results.

Study Indicator 1	
Study Indicator 1 Title	CA 1.5 High Risk with an ICP completed. (77.43%)
Measurement Year Goal	79.90%
Interim Measurement Period	PDSA Cycle 1: 4/1/18-6/30/18 PDSA Cycle 2: 7/1/18-9/30/18
Results	Quarter 1: (2018) 78.65% Quarter 2: (2018) 79.69% (PDSA cycle 1) Quarter 3: (2018) 79.97% (PDSA cycle 2) Quarter 4: (2018) Pending
Study Indicator 2	
Study Indicator 2 Title	CA 1.5 Low Risk with an ICP completed. (68.48%) – 90 days continuous enrollment
Measurement Year Goal	71.00%
Interim Measurement Period	PDSA Cycle 1: 4/1/18-6/30/18 PDSA Cycle 2: 7/1/18-9/30/18
Results	Quarter 1: (2018) 69.54% Quarter 2: (2018) 70.57% (PDSA cycle 1) Quarter 3: (2018) 71.35% (PDSA cycle 2) Quarter 4: (2018) Pending
Updated from 135 days of continuous enrollment to 90 days of continuous enrollment: Reporting Period: 10/1/2017 to 12/31/2017	
Study Indicator 3	
Study Indicator 1 Title	CA 1.6 OCC Members with Documented Discussion of Care Goals (74.81%)
Measurement Year Goal	77.91%
Interim Measurement Period	Quarter 3: (2018) PDSA Cycle 1: 6/1/18-9/30/18 81.69% Quarter 4: (2018) PDSA Cycle 2: 10/1/18-12/31/18 (Data up to 11/5/18) Cumulative Rate (up to end of each cycle/quarter): 1/1/18-9/30/18 1/1/18-11/5/18

Results	PDSA Cycle 1: 6/1/18-9/30/18 Quarter 3: 81.69% PDSA Cycle 2: 10/1/18-12/31/18 (Data up to 11/5/18) Quarter 4: 85.88% Cumulative Rate (up to end of each cycle/quarter): 1/1/18-9/30/18: 79.88% 1/1/18-11/5/18: 80.53%

All study indicator results have improved over the baseline period.

For study indicator CA 1.5, preliminary data analysis for Quarter 2 and Quarter 3, 2018 demonstrates incremental improvement in this measure for both high-risk and low-risk members. For Quarter 2 of 2018, the total percent of high-risk members who were enrolled 90 days or longer who had an initial ICP completed was 79.69%. This represents a 2.26% increase from baseline data. For Quarter 2 of 2018, the total percent of low-risk members who were enrolled 90 days or longer who had an initial ICP completed was 70.57%, which represents a 2.09% increase over baseline data. For Quarter 3, 2018, the percent of high-risk members who were enrolled 90 days or longer who had an initial ICP completed was 79.97%, which represents a 2.54% increase over baseline and a 0.28% increase over Quarter 2. For Quarter 3, 2018, the percent of low-risk members who were enrolled 90 days or longer who had an initial ICP completed was 71.35%. This represents a 2.87% increase over baseline and a .78% increase over Quarter 2.

For study indicator CA 1.6, the baseline measurement for this measure showed that 74.81% of members had a documented discussion of care goals in calendar year 2017. After the implementation of the intervention, the cumulative rate for 1/1/2018–11/5/2018 indicated that 80.53% of members had a documented discussion of care goals. This represents a result that is 5.07 percent greater than the previously reported result for the baseline. Additionally, for cycle 2 (10/1/18-12/31/18; data up to 11/5/18) the rate resulted in 85.88% which is 4.19% greater than cycle 1 and 5.72% greater than the baseline rate. These data reveal a sizeable improvement in the percent of member with a discussion of care goals. As predicted, with an earlier opportunity to discuss care goals, the percent of care goal discussions increased. CalOptima has learned that starting the discussion of care goals at the earliest possible opportunity leads to increased engagement and more fruitful discussions. It also increases the number of members who have the chance to engage in a discussion of their health goals.

While the data show an improvement in the ICP completion rate, it would be helpful to continue monitoring for another cycle to ensure there is a lasting impact.

NEXT STEPS:

ICT participation

CalOptima intends to continue to monitor trends and success of ICT participation. Additional intervention efforts such as re-education to providers and staff about the importance of the information collected from members at intake (i.e., care from outside sources such as specialty medical, behavioral health, and pharmacy) is key to productive ICP planning and ICT meeting

participation. In addition, successful invitations come from quick knowledge of who the providers are and how to contact them to include them in the members care. Having this information readily accessible will help to integrate member care.

Follow Up After Hospitalization for Mental Illness
The BHI department will continue to meet with the MBHO monthly to keep up the momentum of discussing ways to improve the follow up visits for members being discharged from the hospital for mental illness. The HEDIS measure will continue to be monitored with monthly rates of progress being pulled, reviewed and sent to the MBHO for additional analysis. Coordination of care efforts between the MBHO, the hospitals where the members are being discharged from and the providers for follow up appointments is a process that requires a constant feedback loop to be successful in. This is what our partners in care are aiming to accomplish.

ED Utilization for Behavioral Health Services
For this measure, data is pulled from claims submitted for these services and is filtered for specific markers that help in the analysis. While limited in detail, some of the information BHI is able to pull may help to explain the need for members to use the ED for services as opposed to the outpatient office locations. This information will continue to be reported and monitored, however, CMS has made a change to the reporting requirements beginning in 2019 that will not require the plans to submit on a quarterly but annual basis with a quarterly filter.

OCC CA 1.7. Coordination of Care with County Mental Health
The coordination of care between county mental health providers and the MMP is one of the overarching goals that was set for OCC. As a result, CMS has asked plans to work on a variety of measures that focus attention on the member and coordination of care for the variety of services a member requires on the path towards wellness. BHI is currently working on the last portion of the 2018 reporting year for this measurement and intends to continue to allocate efforts towards meeting the goal of coordination and integrated care.

CalOptima Nurse Care Managers (NCM's) Program
The global aim of the project is to reduce avoidable hospitalizations, readmissions, and other adverse events for nursing facility residents in OCC, particularly those related to ineffective coordination of services and support following acute discharges. The LTSS department intends to continue to provide resources to support this goal over the next year.

OCC QIP to Improve 30-day Readmission Rate (Year 3)
CalOptima staff will continue efforts to enhance the TOC program to become a meaningful and successful service to OCC members while considering program resources. TOC team will conduct frequent process evaluations throughout the year to improve the program activities. The TOC team will continue improving internal processes and tools and assess opportunities (i.e., additional staff resources and promotion activities) to improve participation rates for TOC program.

OCC Performance Improvement Project to Improve CA 1.5 and 1.6
CalOptima will continue with this PIP project through 2019 and until the study shows statistically significant improvements for two consecutive years.

SAFETY OF CLINICAL CARE

Review and Follow-up on Potential Quality of Care Issues

In 2018, we established the goals of reducing the number of Quality Of Service (QOS) cases, improving the turn-around-time (TAT), improving the Initial Clinical Review process, and trending the practitioners who are outliers with the number of PQIs.

To address the practitioner trending, a report was developed that rated the number of PQIs or Grievances over the number encounters. The report compares the individual to his/her specialty. In March and October 2018, we ranked those providers with the highest rates. In October, QI worked with the Member Experience Committee to address those providers with the highest rates. A letter was sent to each of the 30 providers identified, and a provider shadow coaching activity was recommended. To date, 6 providers have scheduled the coaching. We will continue to review the trending every 6 months.

Sample Report

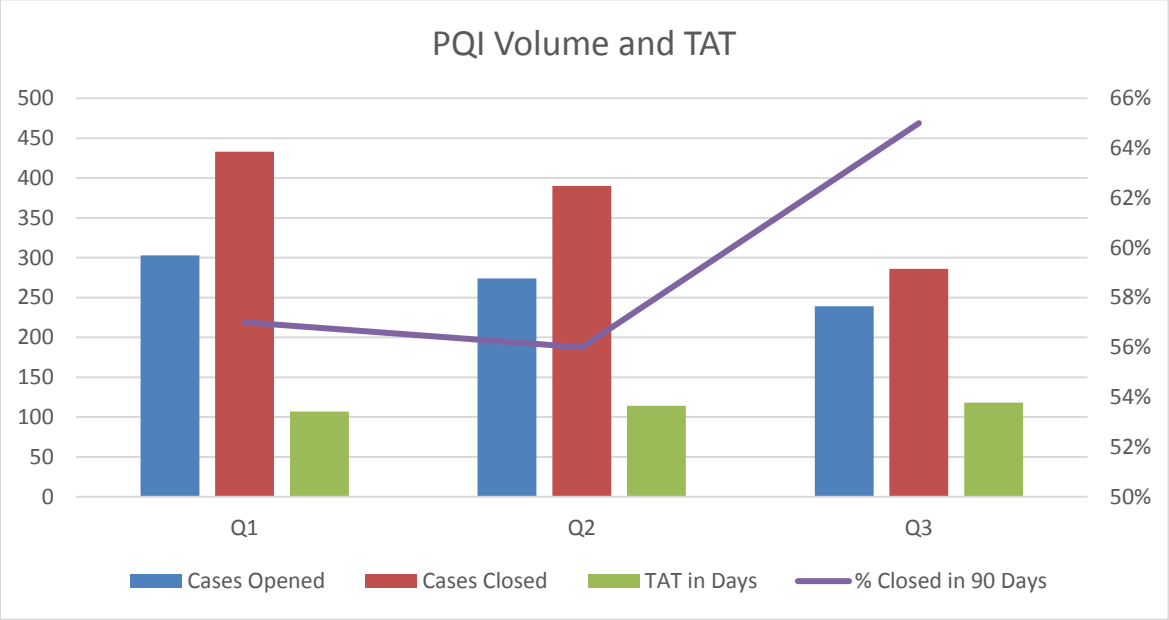
CPRC Activity Report: GARS ≥ 25								**CPRC Activity Report: PQI ≥ 10**							
Cases Closed 7/1/2016 to 7/31/2018								**Cases Closed 7/1/2015 to 7/31/2018**							
Provider Name	**Specialty**	**2Y Pract. GARS Count**	**2Y Spec. GARS Count**	**Claim Count Pract.**	**Claim Count Spec**	**Pract. GARS Rate**	**Spec. GARS Rate**	**Provider Name**	**Specialty**	**3Y Pract. PQI Count**	**3Y Spec. PQI Count**	**Claim Count Pract.**	**Claim Count Spec.**	**Pract. PQI Rate**	**Spec. PQI Rate**
A	Family Medicine	94	1,916	1,061	568,809	88.60	3.37	**A**	Family Medicine	18	686	1,719	843,701	10.47	0.81
B	Internal Medicine	26	1,092	6,136	539,486	4.24	2.02								
C	Internal Medicine	25	1,092	4,390	539,486	5.69	2.02								
D	Family Medicine	74	1,916	6,350	568,809	11.65	3.37	**D**	Family Medicine	20	686	11,146	843,701	1.79	0.81
E	Family Medicine	33	1,916	5,838	568,809	5.65	3.37	**E**	Family Medicine	13	686	8,533	843,701	1.52	0.81
F	Family Medicine	37	1,916	1,773	568,809	20.87	3.37	**F**	Family Medicine	16	686	2,337	843,701	6.85	0.81
								G	Ob/Gyn	11	116	738	223,702	14.91	0.52

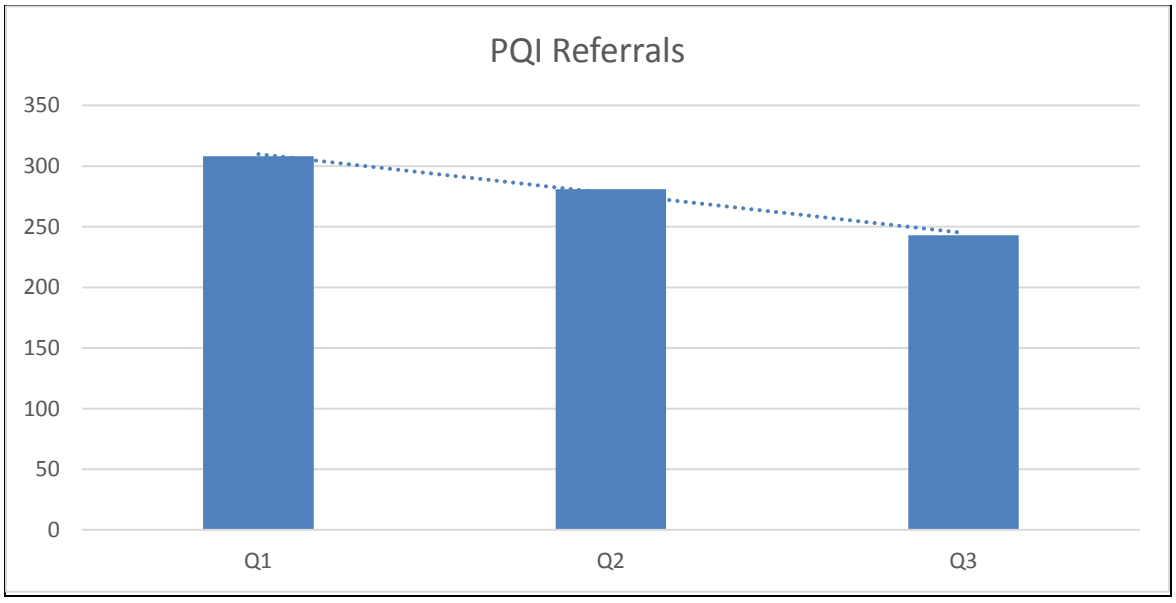
In Q3 2018, we changed the process for receiving PQIs from the GARS department. The cases had been sent to QI toward the end of the GARS review, and many of the cases were QOS. The cases are now sent to a nurse within the first couple of days it is received by GARS. The case is reviewed by the nurse and an Initial Clinical Review is performed to determine if the member has any urgent clinical issue that needs to be addressed. The nurse will assist as needed to coordinate any urgent care. The nurse will then determine if the case is QOS or QOC.

If the case is QOS, the GARS team is notified, and the grievance will be only addressed by the GARS team. If the case is QOC, then a case is opened by QI for an investigation. This process

has: 1) provided quicker clinical support for the member by having a nurse review the case within days of the complaint, and 2) reduced the number of QOS cases in QI, and reduced the overall TAT of cases since the nurse has performed some of the review at the onset.

To further reduce the number of QOS cases and increase the number of QOC case referral, trainings were provided to the Case Management and UM departments. This is demonstrated in the reduction of cases in Q3, and the down trend in the number of cases referred.





Facility Site Review and Physical Accessibility Review Survey

Per DHCS, all PCP sites must have the capacity to support the safe and effective provision of primary care clinical services to Medi-Cal managed care health plans (MCP) members (Title 22, California Code of Regulations [CCR], Section 56230). The Site Review Process is part of a MCP's QI Program that focuses on the capacity of each PCP site to ensure and support the safe and effective provision of clinical services. In order to verify that PCP sites comply with all applicable local, state, and federal standards, CalOptima is required to conduct a Full Scope Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review Survey (PARS) for all PCP sites as part of the initial credentialing process and at least every 36 months thereafter.

In 2018, CalOptima continued to maintain safety standards and practices to their members by completing Facility Site Reviews at all contracted PCP offices. From January-August 2019, CalOptima's team of 3 QI nurses, and 2 Physical Accessibility Review Survey (PARS) reviewers conducted:

- 41 Initial Full Scope Reviews
- 201 Periodic Full Scope Reviews
- 460 PARS

	AVERAGE SCORE	BELOW 80%	ABOVE 80%
ACCESS & SAFETY	**97%**	**0**	**201**
PERSONNEL	**96%**	**3**	**198**
OFFICE MANAGEMENT	**99%**	**0**	**201**
CLINICAL SERVICES	**95%**	**2**	**199**
PREVENTIVE SERVICES	**97%**	**0**	**201**
INFECTION CONTROL	**96%**	**4**	**197**

	AVERAGE SCORE	BELOW 80%	ABOVE 80%
FORMAT	**98%**	**0**	**130**
DOCUMENTATION	**92%**	**8**	**122**
CONTINUITY & COORDINATION	**95%**	**1**	**129**
PEDIATRIC PREVENTIVE	**90%**	**9**	**121**
ADULT PREVENTIVE	**84%**	**35**	**95**
OB/CPSP PREVENTIVE	**0%**	**0**	**0**

Corrective Action Plans (CAP) were issued to sites that scored below 80%. In 2018, there were 35 sites that scored below 80% for Adult preventive Care. FSR nurses actively partnered with sites to ensure CAPS were completed. If a critical element CAP was issued, a site had 10 days to respond with their corrective action plan. For FSR and MRR CAPs, sites have 45 days to respond. Of the CAPS issued, 85% were closed within the required timeframes. There were many reasons for the delays; however, the delays resulted in extra staff time and follow-up to ensure the CAPS were completed by required due dates.

In addition, for physical accessibility of the 460 sites surveyed in Q1-Q3 2018, 48% achieved Basic Access, meeting the required 29 critical elements. The remaining 52% did not meet at least 1 of the 29 PARS critical elements, resulting in Limited Access. Deficiencies were provided to the sites; however, many sites were reluctant to make changes. This is due mostly to cost constraints, as most sites stated that the costs of updates or accommodations would impose an undue financial hardship.

In 2019, the FSR nurses will coach provider offices to ensure CAP closure within appropriate timeframes. As necessary, the team will work with Provider Relations and Health Network Operations to ensure proper closure of CAPs. Additionally, provider trainings will be provided to address issues related to timely CAP closures.

Credentialing of Providers

In 2018, the Credentialing department ensured the safety and quality of the provider network through verification of credentials during the initial and re-credentialing process. Through August of 2018, 680 Initial and Re-credentialed CCN providers were approved. This volume exceeds the number processed in all of 2017. The significant increase in volume is attributed to the doubling of our network with Behavioral Health practitioners. CalOptima continues to credential provider types including physicians, non-physician medical practitioners (NMP), including Behavioral Health and health delivery organizations (HDO). Also, in 2018 pursuant to DHCS All Plan Letter 17-019, CalOptima required all providers to be Medi-Cal enrolled prior to contracting. This requirement is monitored by Credentialing and Provider Data Management Systems, and continues to be required for all contracted providers.

In 2019, the Credentialing department will be focusing on improving turn-around time to ensure timely processing of credentialing applications. This will also help improve access to providers for our members.

Pharmacy — Be Safe Pilot Program

CalOptima has started an opioid monitoring program called Be Safe. The program's aim is to

- Facilitate Be Safe rounds to identify high-risk members
- Develop a plan for member engagement and outreach
- Identify top Morphine Equivalent Dose (MED) utilizers on a weekly basis
- Increase MAT utilization

The Be Safe pilot program will also decrease opioid misuse, promote appropriate prescribing, and decrease adverse events related to opioid misuse through a multidisciplinary approach.

QI ACTIVITIES:

Be Safe rounds allow the care team to respond directly to utilization events with timely tailored interventions. The multidisciplinary team include a RN Case Manager, Behavioral Health clinician, Medical Director, and Clinical Pharmacist. Each of the four disciplines deploy specific, timed interventions that approach and support a member's unique situation.

Be Safe will leverage Controlled Substance Utilization Review and Evaluation System (CURES) reports in monitoring the utilization of opioid to determine treatment success.

TRENDING OF MEASURES / RESULTS:

The first year of this project (2018) was spent developing program objectives and evaluation indicators to be used during the implementation period.

NEXT STEPS:

A multi-disciplinary team has been established for this program, meeting weekly. It is the intent that the group will begin to respond to utilization events in real time. Additionally, the group will identify prescriber trends and member related evaluations to identify unsafe prescribing practices, resulting in a multi-faceted approach to interventions aligned with the program's objectives.

ACCESS & AVAILABILITY

INTRODUCTION:

The Access and Availability subcommittee regularly reviews and monitors the following:

- Appointment availability and telephone access to care through CalOptima's Timely Access Survey
- Network adequacy from our (FACETS) and from our contracted BH vendor, Magellan
- Grievances and Appeals
- Out of Network Requests

Results are reported up to the Member Experience subcommittee and to QIC. Results are also shared with the individual HNs at either the Quality Meetings or the Joint Operations Meetings.

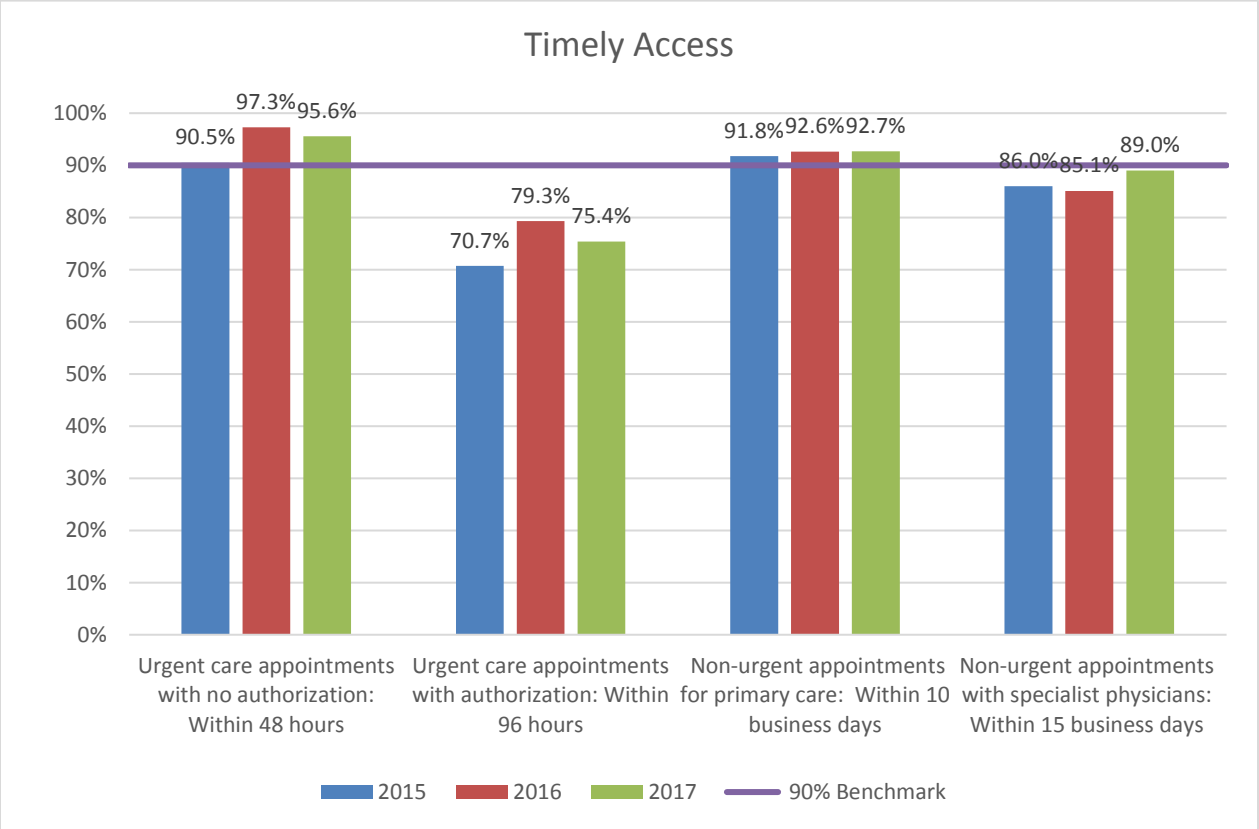
DESCRIPTION OF COMPLETED AND ONGOING QI ACTIVITIES:

Based on our review of our most recent access and availability results which revealed lack of improvement, CalOptima implemented the following activities in 2018:

- Issued an RFP and executed a contract with Centers for Study of Services (CSS) to incorporate a mystery shopper data methodology for the next Timely Access Survey to be fielded in Q1 and Q2 of 2019. The incorporation of the mystery shopper methodology will allow CalOptima to monitor appointment availability performance for all providers rather than to only have collect data from providers who chose to participate in the survey. This will allow CalOptima and its HNs to determine exactly which providers are non-compliant with the access standards, and provider outreach and education can be targeted. In addition, the data collected will be more accurate, since it will no longer be provider self-reported.
- Sent out notification letters to physicians who were over-capacity based on the 1:2000 member to provider ratio.

- Completed and closed out the QIPs issued to the HNs for MY 2016.
- Issued more prescriptive QIPs for MY 2017 on December 2018. In the past, CalOptima has requested HNs develop their own plans to improve access. This approach was not effective as the plans from the HNs were not robust enough to improve performances. As a result, CalOptima has identified interventions for the HNs to implement and will determine if this approach is more successful.
- When CalOptima was notified by the MBHO that they would be ending the contract to service Medi-Cal membership, CalOptima negotiated with the MBHO and terms were not reached. This prompted the transition to Medi-Cal services being provided in-house by CalOptima that began on 1/1/2018.
- For the transition of MBHOs, Network Development representatives actively engaged BH providers in Orange County for contracting and continued these efforts with the Provider Credentialing department throughout the year.
- BHI is currently working with providers on Letters Of Agreement (LOAs) and Registration as BH providers.
- Active intervention occurred to survey providers with specific questions related to their specialty, comfort level and experience in providing specific services for special populations. The purpose of the survey was to generate a list of providers able to refer to for special case services, i.e. gender transformation, eating disorders, etc.

TRENDING OF TIMELY ACCESS MEASURES/RESULTS AND ANALYSIS



CalOptima annually fields a Timely Access Survey to monitor appointment availability and telephone access during and after business hours. In 2018, CalOptima issued an RFP to seek a new survey vendor to field a Timely Access Survey that would include a mystery shopper data collection methodology. Due to this change in methodology leading to a lengthy contracting process, the Timely Access Survey was not fielded in 2018, but will be delayed until Q1 2019.

As a result, the above table represents three years of timely access from 2015-2017. It shows trending for four regulatory measures related to urgent/non-urgent primary and specialty appointment availability in the Timely Access Study. CalOptima has met timely access measures for primary care appointment availability, but not for specialty appointment availability. In 2017, there was an increase in ”non-urgent appointments with specialist physicians within 15 business days” and a slight decrease in both urgent care appointment measures.

The Timely Access Study also monitors telephone access during and after business hours. CalOptima also did not meet the following areas (minimum performance set at 90%): provider returning urgent messages during business hours within 30 minutes, having a message that instructs the member to dial 911 or go to the nearest emergency room (in an emergency), and having proper triage and screening.

Behavioral Health Timely Access Survey

Specialty Care Accessibility Survey Results

	Results	Goal Met? (90%)
Urgent - All Providers: Care for a non-life-threatening emergency within 6 hours	(175/207) **85.2%**	Not Met
Urgent Care Services - All Providers: available within 48 hours of request for appointment	(1/1) **100%**	Met
Routine - non-MD Routine care (i.e. psychologists, licensed clinical social workers(LCSW), marriage and family therapist (MFT) appointment within 10 business days	(111/127) **87.4%**	Not Met
Routine - MD Routine care (i.e. psychiatrist) appointment within 15 business days	(61/70) **87.1%**	Not Met
Follow - up for routine care: visits at a later, specified date to evaluate patient progress since last visit.	(196/235) **83.4%**	Not Met

CalOptima’s performance goal of 90% was not met for any of the access standards for BH services during this measurement year, with the exception of Urgent Care services by all providers within 48 hours of request for appointment category (100% met with only 1 request made during 2017). The performance goals have traditionally been met in the past. In reviewing the practitioner-level data, there were no trends in appointment access by geographic region.

TRENDING OF NETWORK ADEQUACY MEASURES/RESULTS AND ANALYSIS

CalOptima monitors our provider network quarterly to ensure that there is adequate coverage for our members to access care. Reports are run quarterly to determine if our provider network meets all regulatory requirements and the provider/member ratios, distance/time and other access standards set in CalOptima's access and availability policies. For 2018, DHCS issued new network adequacy standards that were effective July 1, 2018. Efforts were made to update our reporting templates and monitor our provider network against the new standards.

For 2018, CalOptima has meet all the regulatory network adequacy requirements, including BH, for DHCS and CMS for all lines of business set at 100% minimum performance for distance or time. The reports indicate that some areas were not met, according to standards in our policy, at the plan level. For those areas of non-compliance, most of the time the score was slightly below the required 100% compliance rate, usually at a 99.99%. When looking deeper into the data, it was determined that there were a few members that lived in a more remote area in south Orange County and did not have a provider of that type within the required distance/time standard. CalOptima is now looking into this issue. When looking at network adequacy at the HN level, there are some provider specialty types that do not meet the set standards and CalOptima will work with those HN to improve network adequacy.

EVALUATION OF RESULTS

For 2018, CalOptima met all the primary care timely access and network adequacy standards. However, CalOptima did not meet the timely access standards for specialty care (urgent and routine) and network adequacy for some provider types were also not met. As a result, the Access and Availability subcommittee has identified access to specialty care to be the areas of focus for 2019 and work on the following:

- Issue prescriptive QIPs to the HNs, including CCN. HNs will be asked to complete the following:
    - Barrier analysis for areas of non-compliance
    - Audit and/or education to providers who did not meet access standards
    - Audit and education to newly contracted providers on access standards
- Share with the HNs a detailed provider contracting file for them to validate. If there is an error, the HNs would be expected to resolve the error.
- Field a Timely Access Survey in 2019 with a mystery shopper data collection methodology. This methodology would allow CalOptima to capture data from all contracted providers rather than to rely on mail-in provider self-reported data where only providers who complete the survey are evaluated.
- Continue to work with our Provider Relations, Provider Credentialing and Contracting departments to recruit for in-demand provider types.

MEMBER EXPERIENCE

INTRODUCTION:

The Member Experience subcommittee regularly reviews and monitors the following:

- Member experiences or CAHPS survey results at the plan and HN level
- Customer Service data
- Grievances and Appeals
- Behavioral Health Member Experience Survey

Results are reported up to the QIC. Results are also shared with the individual HNs at either the Quality Meetings or the Joint Operations Meetings.

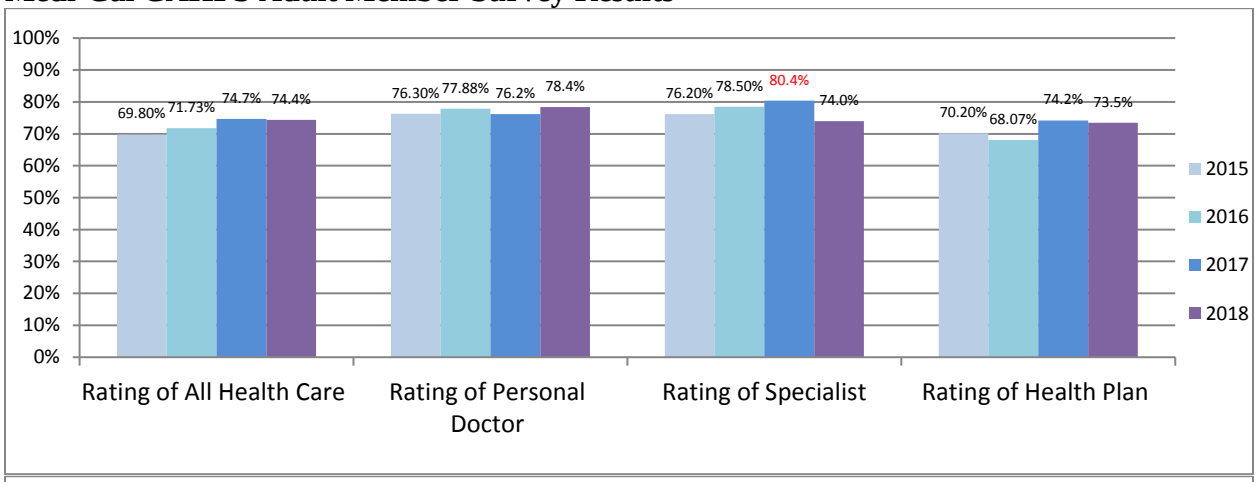
DESCRIPTION OF COMPLETED AND ONGOING QI ACTIVITIES:

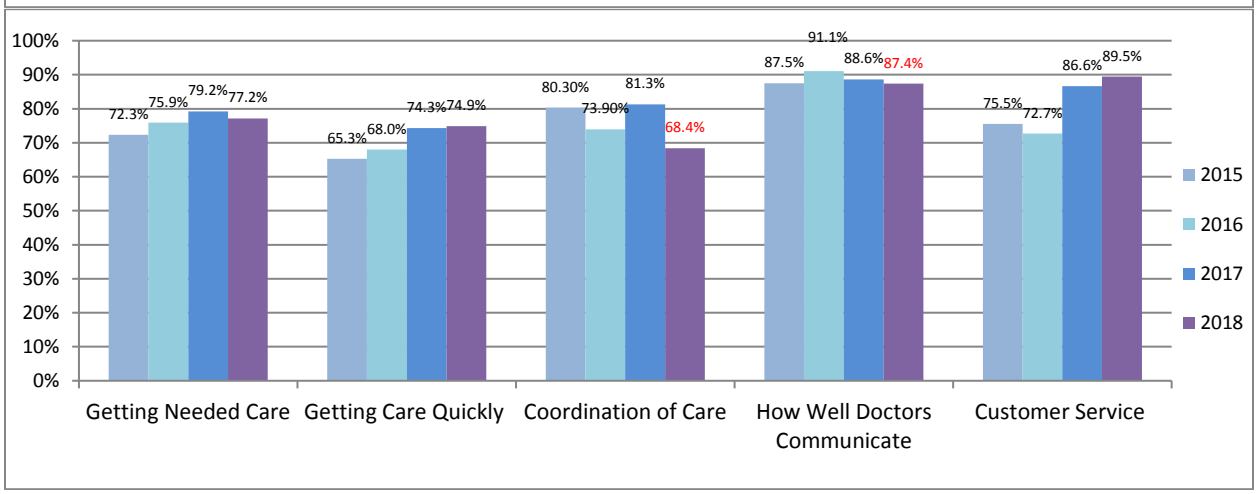
Based on our review of our most recent member experience results which revealed lack of improvement and a downward trend for several areas, CalOptima implemented the following activities in 2018:

- Contracted with SullilvanLuallin Group, a customer service improvement health care consultant, to conduct shadow coaching with 25 providers and to hold workshops on customer service for office staff, office managers/supervisors and physicians to improve over patient experience.
    - Outreach to middle performing providers for shadow coaching yielded low participation. As a result, we expanded provider coaching and customer service workshops to HNs and target 30 physicians with high volume of grievances and potential quality issues (PQIs).
    - Progress-to-date for customer service workshops: Conducted 2 customer service workshops on November 2, 2018 (12-staff; 19 supervisors/managers). Feedback from participants is very positive.
    - Progress-to-date for shadow coaching: 6 providers completed shadow coaching and 6 providers were scheduled for shadow coaching in December 2018.
- Letters were sent to 30 physicians notifying them of their high volume of grievances and PQIs.
- Issued an RFP and executed a contract with SPH Analytics to field a provider level member experience survey (CG-CAHPS) in 2019.
- BHI is actively developing required documents to request vendor to perform a BH member experience survey in 2019 for services rendered in 2018. Survey was previously fielded by CalOptima's contracted BH vendor and the survey was then delegated. CalOptima will be managing this survey.
- Continued to incentivize member experience as part of our P4V program. Unfortunately, this has not helped improve our member experience scores. The P4V Steering Committee is considering revising how incentive payments are distributed.

TRENDING OF MEASURES/RESULTS AND ANALYSIS

Medi-Cal CAHPS Adult Member Survey Results



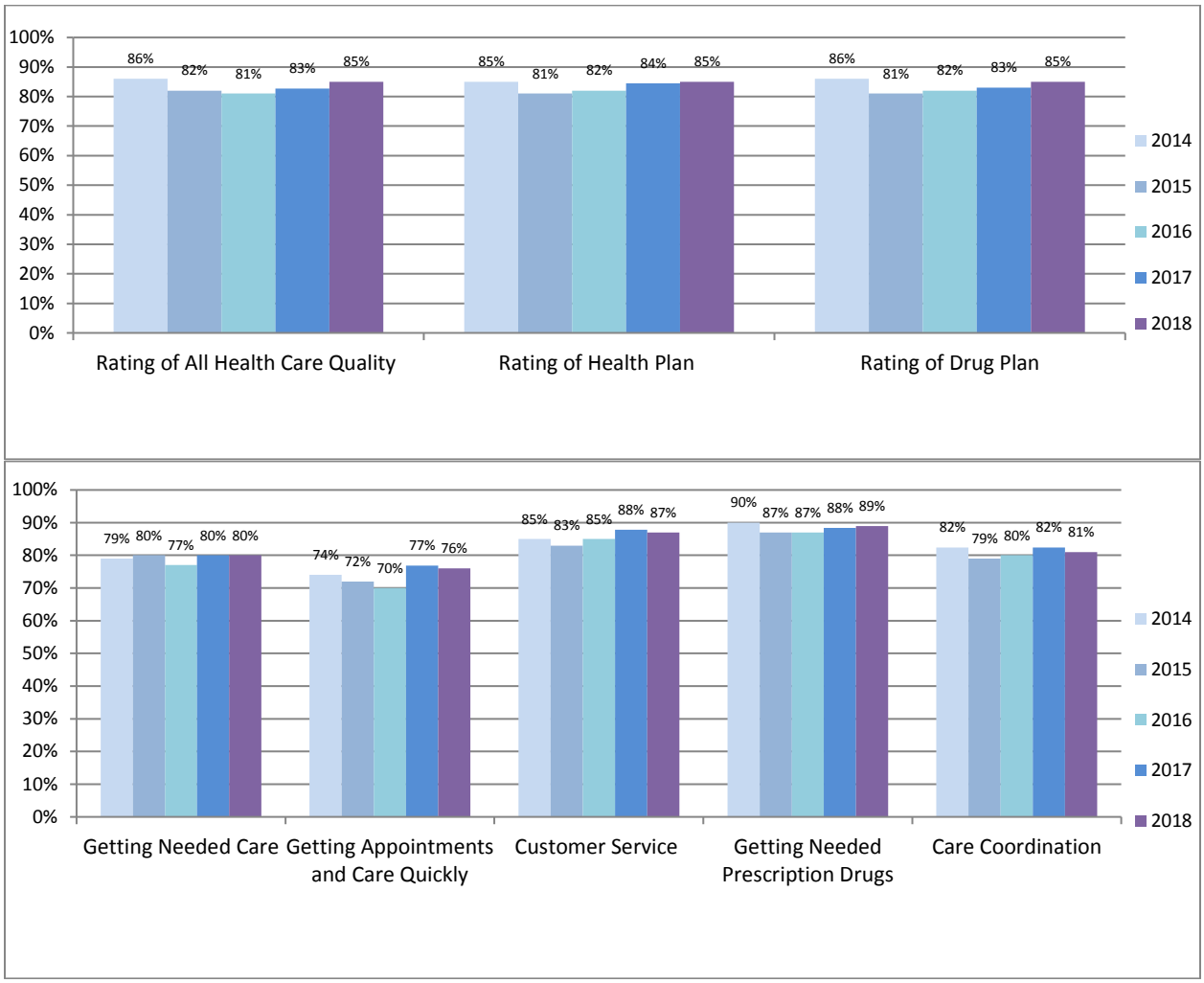


For Medi-Cal adult survey, the 2018 scores are generally consistent with the score from the previous year (25th percentile) while member experience benchmarks continue to rise. For 2018, Coordination of Care which had a significant decrease of 12.9 percentage points from the previous year, also did not meet the National or California NCQA 25th percentile. While the measure How Well Doctors Communicate had a high percentage score, it also did not meet either the National or California NCQA 25th percentile. Since CalOptima began fielding the Medi-Cal Adult Survey, we have seen steady increase in the following areas: Rating of All Health Care, Getting Care Quickly and Customer Service. Decreases in scores have been identified for the following measures: Coordination of Care and How Well Doctors Communicate.

Medi-Cal CAHPS Child Member Survey Results

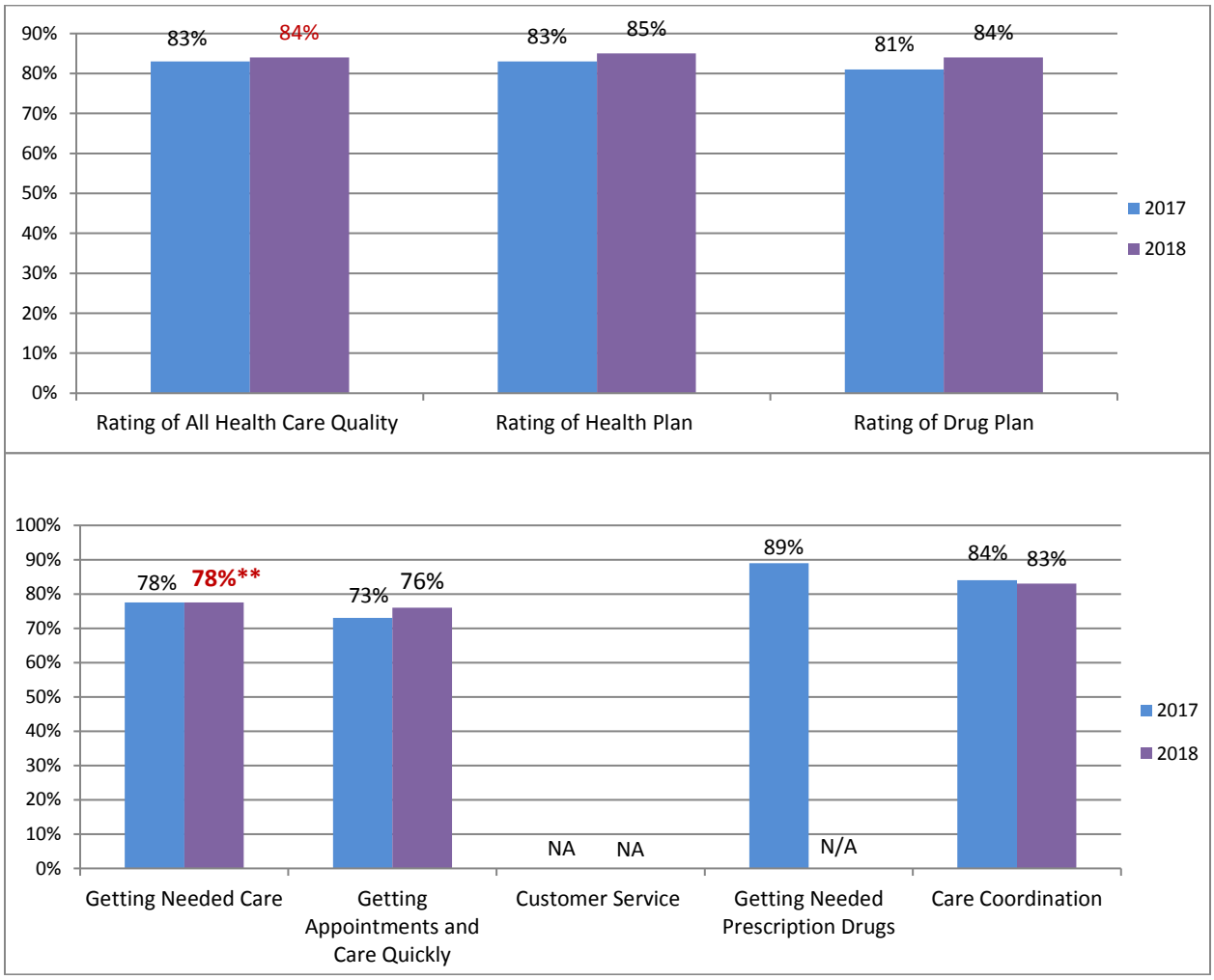
For the Medi-Cal child survey, the 2018 scores improved from the previous year, particularly in Rating of Health Plan. For 2018, Getting Care Quickly did not meet the National or California NCQA 25th percentile. Since CalOptima began fielding the Medi-Cal Child Survey, we have seen steady increase in the following areas: Rating of Health Plan, How Well Doctors Communicate and Customer Service. Decreases in scores have been identified for Rating of Specialist.

OC CAHPS Member Survey Results



For the OC survey, the 2018 scores are generally consistent with the score from the previous year, 3-star for the overall rating questions and a 2-star for the composites. For 2018, Customer Service and Care Coordination have received only 1-star. For the past 5 years, we have seen a small dip in a score and then an increase in the past couple of years. Increases can be seen in the follow measures: Getting Appointments and Care Quickly and Customer Service. Decrease can be seen in Care Coordination, Customer Service and Getting Appointments and Care Quickly from the previous year. Some scores were not available due to low reliability and were not eligible for CMS Star Ratings. Low reliability may be due to OC's small population size of only 1,404 members as of October 31. 2018.

OCC CAHPS Member Survey Results



For the OCC survey, scores are only available for the past 2 years. The 2018 scores improved previous year, particularly in Rating of Health Plan, Rating of Drug Plan, and Getting Appointments and Care Quickly. Currently, there are no CMS benchmarks available for OCC. Some scores were not available due to low reliability.

Behavioral Health Member Survey Results

The 2018 Member Experience survey results were analyzed for 2017 services. The next survey will take place in 2019 for 2018. CalOptima Minimum Performance Level (MPL) is considered as 90% met for 1 provider within 30 miles or 45 minutes time at all provider levels for BH services. BH met the MPL at 100% access using the MBHO standard, delegated at the time, of provider available in an location that is considered Urban: 1 in 10 miles and Suburban: 1 in 25 miles. This was reported by the MBHO. The 2018 Member Experience survey is not fielded until the first quarter in 2019. The goal is to achieve an 85% member satisfaction rate for BH services overall. Last and previous years these services were delegated and we saw a slight increase in satisfaction over the years, building momentum.

EVALUATION OF RESULTS

Analysis of the member experience or CAHPS scores, supplemented by the grievances and appeals and customer service data, indicate that members are not satisfied with the following areas:

- How Well Doctors Communicate
- Customer Service
- Referral and Authorizations
- Coordination of Care

For the next year, the OC and OCC population will be oversampled for the CAHPS survey to increase reliability. There will also be continued efforts to improve How Well Doctors Communicate and Customer Service. CalOptima staff will continue implementing provider shadow coaching and workshops in partnership with HNs. At this time, there are 4 HNs who have shown interest in collaborating. CalOptima will also field a provider level member experience survey (CG-CAHPS) to monitor provider level performance and evaluate the Provider Coaching Pilot. For CG-CAHPS, individual provider will be made aware of their performance through CG-CAHPS provider report cards. The Member Experience subcommittee has also identified referrals and authorizations and coordination of care of the areas of focus for 2019. A workgroup has been formed to focus on mapping out the referral and authorization process from the members' perspective and identifying opportunities for improvement. In the area of BH, CalOptima will execute a contract with a survey vendor to field a BH Member Experience Survey that will assist in the identification of member pain points.

SUMMARY

CalOptima proudly achieved being the top-rated Medicaid plan in California for the fifth year in a row, according to the NCQA Medicaid Health Insurance Plan rating 2018-2019. CalOptima's completed the tri-annual renewal survey, and successfully achieved a commendable accreditation status by NCQA for 2018. CalOptima developed and implemented programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Ongoing data analysis across multiple areas provides the basis for identifying over/under utilization of services. Our approach also uses support systems for our members with vulnerabilities, disabilities and chronic illnesses. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, as reflected in the 2019 QI Workplan, we are confident that our QI efforts will continue to make a positive impact.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 20, 2019
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

3. Consider Recommending Board of Directors' Approval of the CalOptima 2019 Quality Improvement (QI) Program and 2019 QI Work Plan

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, RN, MS, LSSMBB, Executive Director, Quality & Population Health Management, (714) 246-8400

Recommended Actions

Recommend Board of Directors' approval of the recommended revisions to the 2019 Quality Improvement Program and 2019 Quality Improvement Work Plan.

Background

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

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

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

CalOptima staff has updated the 2019 QI Program Description and Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks and strategic organizational changes. This will ensure that all regulatory requirements and National Committee of Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business.

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The revisions are summarized as follows:

1. Updates signature page (replaces CMO to David Ramirez, MD).
2. Simplifies the plans we offer, scope of services and who we work with, including an updated list of our Health Networks.
3. Updates new initiatives on the horizon, including Whole-Person Care, Whole-Child Model, Health Homes Program, and Population Health Management.
4. Updates Quality Improvement Program purpose to include Population Health accountability, annual review, and acceptance not limited to Utilization Management.
5. Updates Authority, Board of Directors' – Quadruple Aim which includes enhancing provider satisfaction.
6. Updates the QI committee structure and subcommittees that support the QI Program.
7. Incorporates the description of CalOptima's approach to Population Health Management in the design and delivery of care.
8. Establishes 2019 QI Goals and Objectives aligned with CalOptima's strategic objectives.
9. Updates the 2019 QI Work Plan to reflect new goals and objectives.
10. Introduces methodology of lead and lag indicators reflected in the QI Work Plan.
11. Includes communication of QI activities to Quality Forum.
12. Updates staff responsibilities and position descriptions.
13. Adds QI Lean Training Curriculum to CalOptima University in 2019.
14. Includes de-credentialing to Corrective Action Plans.
15. Adds new sections: Population Health Management, Long-Term Services and Supports, and Behavioral Health Integration.
16. Adds Group Needs Assessment and Population Health Management to Safety Section
17. Adds Chinese and Arabic to Cultural & Linguistic services.
18. Updates 2019 Delegation Grid to include NCQA elements for Population Health Management.

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

Fiscal Impact

The recommended action to approve the 2019 QI Program and 2019 QI Work Plan has no additional fiscal impact for Fiscal Year (FY) 2018-19. To the extent that there is any fiscal impact due to increases in Quality Improvement Program resources and incentives from July 1, 2019, through December 31, 2019, such impact will be addressed in separate Board actions or the CalOptima FY 2019-20 Operating Budget.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Proposed 2019 Quality Improvement Program – Executive Summary of Revisions
2. Proposed 2019 Quality Improvement Program and QI Work Plan
3. Power Point Presentation: 2019 Quality Improvement Program and Work Plan

/s/ Michael Schrader — *2/14/2019*
Authorized Signature — **Date**

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Quality Improvement (QI) Program 2019
Executive Summary of Revisions

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2019

QUALITY IMPROVEMENT PROGRAM

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2019 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

David Ramirez, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

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. 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 our members.

Our Values — CalOptima CARES

C ollaboration: 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.

A ccountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, 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.

R espect: 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.

E xcellence: 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

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.

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 optional 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

Medi-Cal

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving 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, 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.

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.
- Eligible conditions under California Children's Services (CCS). Effective July 1, 2019, or such later date as the program becomes effective, this program will be managed by CalOptima through the Whole-Child Model (WCM) 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 CalOptima's member liaisons and through specific Memoranda of Understanding (MOU) with certain community agencies, including OC HCA, CCS (through June 30, 2019, or such later date as the Whole-Child Model becomes effective) and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

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

These integrated LTSS benefits include three programs:

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

OneCare (HMO SNP)

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

OC provides a comprehensive scope of services for 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 services covered under Medi-Cal and Medi-Care benefits, CalOptima OC members are eligible for enhanced services such as transportation to medical services and gym membership.

OneCare Connect

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

These members often 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.

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 is 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 services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits

such as vision care and gym benefits. 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 seniors to help them continue living independently in the community.

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

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

NEW PROGRAM INITIATIVES

Whole-Person Care
Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2020 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 Connect information sharing platform was launched in November 2018. For 2019 the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model
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.

Through SB 586, the State has required CCS services to become a Medi-Cal managed care plan benefit in select counties. The goal is 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 the Whole-Child Model (WCM). Under this model, in Orange County, eligibility determination processes and the Medical Therapy Program 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

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

CalOptima plans to implement HHP in the following two phases: July 1, 2019 for members with chronic physical conditions or substance use disorders (SUD), and January 1, 2020 for members with serious mental illness or Serious Emotional Disturbance (SMI).

DHCS is targeting the highest-risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. DHCS will 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 home providers. In addition to CalOptima's Community Network, some HNs 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

Population Health Management (PHM)

CalOptima has developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy including plan of action for addressing our culturally diverse member 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 the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The 2019 PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in

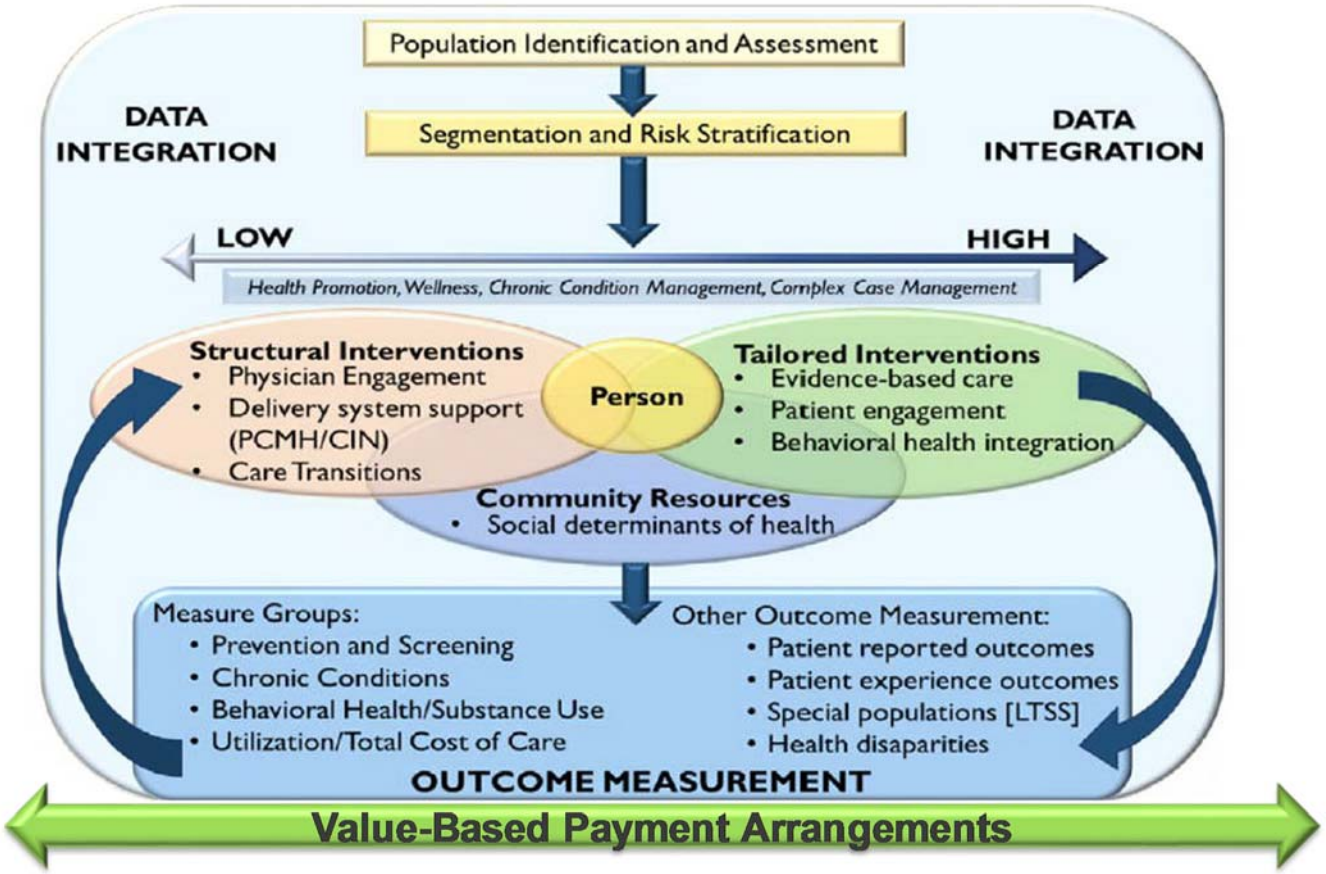
March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.

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

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 as illustrated below in Figure 1. The PHM Conceptual Model is adapted from the model created by the Association of Community Affiliated Plans. CalOptima added the PHM Value Based Payment Arrangement as the foundation to align the future Pay for Value program methodology.

See Appendix C — 2019 PHM Strategy

Figure 1.PHM Conceptual Model



WHOM WE WORK WITH

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima HN, and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose one of 14 HNs, representing more than 8,400 practitioners.

Health Networks
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 nearly 1,600 Primary Care Providers (PCPs), more than 6,800 specialists, 23 hospitals and 23 clinics and 100 long-term 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-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct 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. Currently, CalOptima contracts with 13 HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.

The following are CalOptima's contracted HNs:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		

Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
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
A Public Agency
Better. Together.

Fast Facts: January 2019

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, 2018

Total CalOptima Membership
769,216

Program	Members
Medi-Cal	752,888
OneCare Connect	14,610
OneCare (HMO SNP)	1,423
Program of All-Inclusive Care for the Elderly (PACE)	295

Note: The Fiscal Year 2018-19 Membership Data started on July 1, 2018.

Member Age (All Programs)

11%	0 to 5
30%	6 to 18
29%	19 to 44
18%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
28%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

43%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care

QUALITY IMPROVEMENT PROGRAM

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

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care coordination, PHM, complex case management, behavioral health integration, and palliative care. Our comprehensive person-centered approach leverages the care delivery systems and community partners for our members with vulnerabilities, disabilities and chronic illnesses.

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

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

QUALITY IMPROVEMENT PROGRAM PURPOSE

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

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

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by NCQA, and meet DHCS/CMS quality requirements and measurement reporting requirements.

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

- Sets expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes.
- Supports the provision of a consistent level of high quality of care and service for members throughout the contracted provider networks, as well as monitors utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Provides oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensures certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — OC HCA — which may include, but are not limited to, methicillin resistant *Staphylococcus aureus* (MRSA), scabies, tuberculosis, etc., as reported by the HNs.
- Promotes patient safety and minimizes risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and works with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences.
- Educates the workforce and promotes a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes apply to populations served by CalOptima's contracted HNs, including CCN and/or COD-A Network Providers, to:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently.
- The continuous improvement of clinical care and services quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- The timely identification of important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care.
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- The accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- The continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- The reliability of risk prevention and risk management processes.
- The compliance with regulatory agencies and accreditation standards.
- The accountability cadence of annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.

- The effectiveness and efficiency of internal operations.
- The effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values.
- The compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

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

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors

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

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board of Directors 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 QI Program annually.

The QI Program is based on ongoing data analysis to identify the clinical needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

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

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to 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 shall also make recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim moving upstream 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 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. The meetings 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 will provide advice and recommendations to the Board and staff on issues concerning WCM, serve as liaison between interested parties and the Board, and assist 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 to 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 meetings are open to the public.

Role of CalOptima Officers for Quality Improvement Program

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

Chief Medical Officer (CMO) — or physician designee — chairs the QIC, which oversees and provides direction to CalOptima's QI activities, and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Chief 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.

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the company-wide QI Program deployment, driving improvements in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining commendable accreditation with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO and ED of Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and programs throughout the company and makes certain that quality initiatives are aligned with Clinical Operations within Medical Affairs. Reporting to the ED of Q&PHM: Director, Quality Analytics; Director, Population Health Management; Director, Behavioral Health Services; and Director of Quality Improvement.

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

Executive Director, Public Affairs (ED of PA) serves as the State Liaison; and is responsible for the management, development and implementation of CalOptima's Communication plan, Issues Management and Legislative Advocacy. This position also oversees Strategic Development and the integration of activities for the Community Relations Program.

Executive Director, Compliance (ED of C) is responsible for monitoring and driving interventions so that CalOptima and its HMOs, PHCs, SRGs, and other FDRs meet the

requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs, and other functional areas. The ED of C also oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

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

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

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)

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

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted HMOs, PHCs, SRGs, and MBHOs to achieve the result of improved care and services for members. The QIC oversees the performance of delegated functions by its HMOs, PHCs, SRGs, and MBHOs and their contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed, and identification of opportunities to improve care.

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

Responsibilities of the QI Committee include the following:

- Recommends policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.
- Oversees the analysis and evaluation of QI activities.
- Makes certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI program activities.
- Identifies and prioritizes needed actions and interventions to improve quality.

- Makes certain that there is follow-up as necessary to determine the effectiveness of quality-improvement-related actions and interventions.

Practice patterns of providers, practitioners, HMOs, PHCs, SRGs, and MBHOs are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CalOptima standards.

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

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, HMOs, PHCs, SRGs, and MBHOs.

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

- **Plan** Detailed description and goals
- **Do** Implementation of the plan
- **Study** Data and collection
- **Act** Analyze data and develop conclusions

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

Voting Members

- Four (4) physicians or practitioners, with at least two (2) practicing physicians or practitioners
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Executive Director, Quality & Population Health Management
- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six (6) voting members of which at least four (4) are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

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

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

Minutes of the Quality Improvement Committee and Subcommittees

Contemporaneous minutes reflect all Committee decisions and actions. These minutes are dated and signed by the Committee Chair to demonstrate that they are representative of the official findings of the committee.

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

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

All agendas, minutes, reports, and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and not reproduced (except for Quality Profile documentation) in order to maintain confidentiality, privilege and protection.

Credentialing Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. In addition, the CPRC reviews and monitors sentinel events, quality of care and services trends across the entire continuum of CalOptima's contracted providers: HMOs, PHCs, SRGs, and health care delivery organizations to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Grievance and Appeals Resolution Services Committee (GARS)

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

through the QIC. The voting member composition and quorum requirements of the GARS are defined in its charter.

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

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, and MBHOs to identify areas of under or over utilization that may adversely impact member care. The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as development of Evidence Based Clinical Practice Guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UMC meets quarterly and reports through the QIC. The voting member composition (including a Behavioral Health practitioner*) and the quorum requirements of the UMC are defined in its charter.

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

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

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

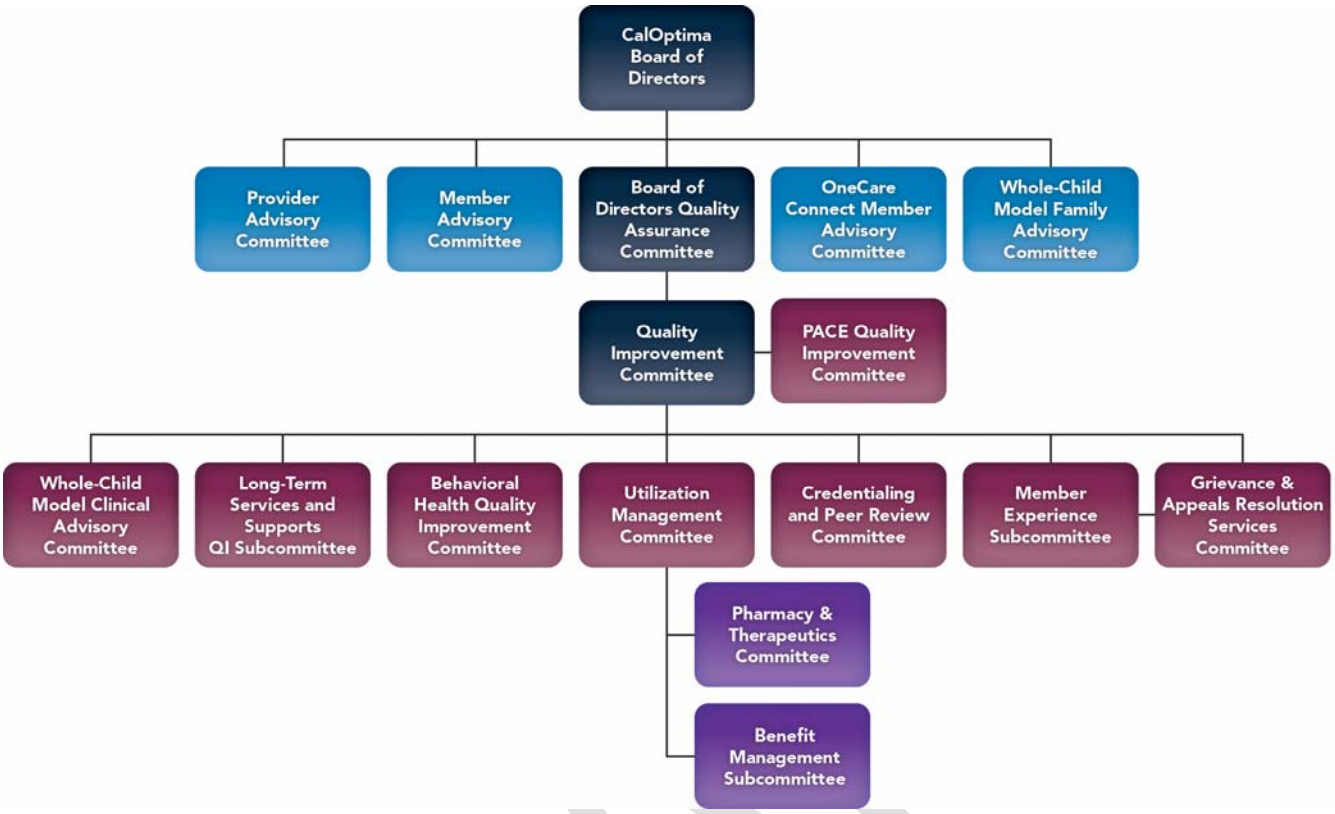
Long-Term Services and Supports QI Subcommittee (LTSS-QISC)
The LTSS subcommittee is composed of representatives from the LTC, CBAS, and MSSP communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of criteria and methodologies to measure and report quality and access standards with HCBS and in LTC facilities where CalOptima members reside. The LTSS subcommittee also serves to identify best practices, monitor over and underutilization patterns, and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports through the Clinical Operations subcommittee, and through the QIC. The voting member composition and quorum requirements of the LTSS-QISC are defined in its charter.

Behavioral Health Quality Improvement Committee (BHQIC)
The BHQIC ensures members receive timely and satisfactory behavioral health care services, through enhancing integration and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement, and guiding CalOptima towards the vision of bi-directional behavioral health care integration. The designated chairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible for chairing the committee and reporting through the QIC. The BHQIC meets, at a minimum, on a quarterly basis, or more often as needed. The voting member composition and quorum requirements of the BHQIC are defined in its charter.

Member Experience Subcommittee (MEMX)
Improving member experience is a top priority of CalOptima. The MEMX was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC, and OCC. NCQA Medicaid Plan Ratings measure three dimensions – Prevention, Treatment and Customer Satisfaction. CalOptima's QI Program focuses on the performance in each of these areas. The MEMX is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. In 2019, the MEMX will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the 2020 CAHPS survey results. This subcommittee meets at least bi-monthly and is reported through the QIC. The voting member composition and quorum requirements of the MEMX are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)
The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-011. The WCM CAC will advise on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensure they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee, and HN CCS providers. The WCM CAC meets 4 times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

2019 Committee Organization Structure — Diagram



Confidentiality

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

All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs, SRGs and MBHOs hold all information in the strictest confidence. Members of the QI Committee 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.

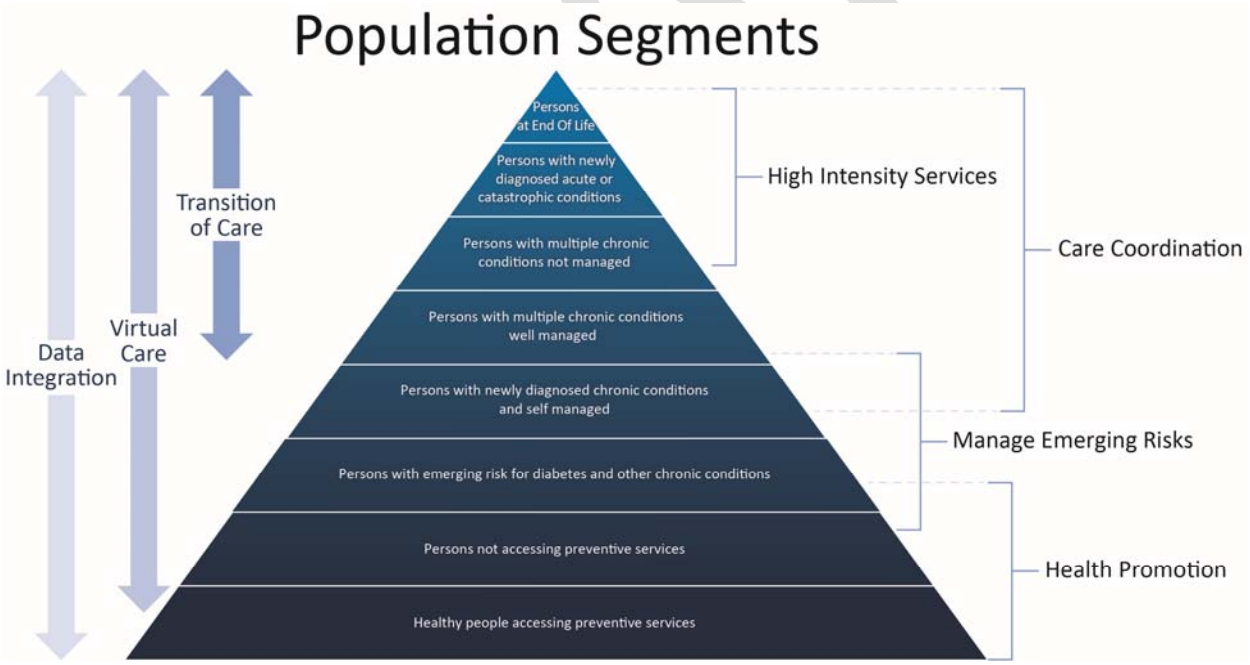
Conflict of Interest

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

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program supports a Population Health Management (PHM) approach, stratifying our population based on their health needs, conditions, and issues and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care, the 2019 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health.

The Population Segments with an integrated intervention hierarchy, is shown below:



CalOptima's Model of Care (MOC) recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of the high-risk members one-by-one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile

technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

2019 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2017–2019 strategic goals.

1. **Goal: Achieve NCQA overall rating as the #1 Medi-Cal Health Plan in California by:**
   1.1. Improving NCQA ratings in Member Experience from 1.5 to 3.0
   1.2. Improving NCQA ratings in Treatment from 3.5 to 4.0
2. **Goal: Improve overall Health Networks, including CCN, quality performance rankings by:**
   2.1. Implementing practice transformation technical assistance in 5 high volume CCN practices by December 2019.
   2.2. Expanding provider coaching and customer services training to include all health networks and all PQI providers and office staff in CCN by December 2019.
3. **Goal: Improve Member Experience CAHP performance from 25th percentile to exceed 50th percentile by:**
   3.1. Increasing the number of providers who have a high rate of grievances and PQIs who will participate in provider coaching and customer services training by December 2019.
   3.2. Expanding provider coaching and customer services training to all health networks providers and office staff on the PQI list by December 2019.

Detailed strategies for achieving 2019 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly, and evaluated annually.

QI Measurable Goals for the Model of Care

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

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

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

QI Work Plan

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

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

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

- Quality of Clinical Care
- Safety of Clinical Care
- Quality of Service
- Member Experience
- Compliance
- QI Program Oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of CalOptima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of CalOptima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

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

See Appendix A — 2019 QI Work Plan

Methodology

QI Project Selections and Focus Areas

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

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality concern (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e)

satisfaction surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis.
- Measures required by regulators such as DHCS and CMS.

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

- Access to and availability of services, including appointment availability, as described in the UM Program and in policy and procedure
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

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

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

QI Project Quality measures

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

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

QI Project Measurement Methodology

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

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

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

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

Do 5) Communicate change plan
6) Implement change plan

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

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

Communication of QI Activities

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI work plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

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

QUALITY IMPROVEMENT PROGRAM RESOURCES

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

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

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

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the 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 Work Plan implementation.

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

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

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

Director, Population Health Management
Provides direction for program development and implementation for agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health

programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

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

Director, Behavioral Health Services provides operational oversight for behavioral health benefits and services provided to members. The director is responsible for monitoring, analyzing, and reporting on changes in the health care delivery environment and identifying program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.

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

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

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

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

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

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

Staff Orientation, Training and Education

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

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

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies & procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency training
- QI Lean training curriculum will be added to CalOptima University in 2019

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

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

Annual Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC, QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for

formulating the next year's initiatives and incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of each QI Activity, including QI Projects (QIPs), with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement.
- An evaluation of member satisfaction surveys and initiatives.
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.
- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors review and approval.

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

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

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

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

The important aspects of care and service around which key business processes are designed include:

- Clinical Care and Service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions

- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/under utilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

*** CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.**

QUALITY IMPROVEMENT

The QI department is responsible for the execution and coordination of quality assurance and improvement activities. It also supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both division and department-specific as well as agency-wide
- Evaluate and monitor provider credentials

- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain agency-wide practices that support accreditation and meeting regulatory requirements.

Peer Review Process For Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, tracking and trending of service and access issues are reported to the CPRC and are also reviewed at time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or GARS.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctor of podiatric medicine), DC (doctor of chiropractic medicine), DDS (doctor of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities are delegated to the HNs and performed by CalOptima for CCN.

Health Care Delivery Organizations

CalOptima performs credentialing and re-credentialing of Health Care Delivery Organizations (HDOs), also known as Organizational Providers (OPs) for providers such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of QI Activities in the Re-credentialing Process

Findings from QI activities are included in the re-credentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations

on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates Facility Site Review (FSR) and Medical Record Review (MRR) for the non-delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room
- Exam table/scale

Medical Record Documentation Standards

CalOptima requires that its contracted HMOs, PHCs, and SRGs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.

Corrective Action Plan(s) To Improve Care, Service

When monitoring by either CalOptima's QI department or Audit & Oversight department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e. quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education or office training
- De-delegation
- De-Credentialing
- Contract termination

Performance Improvement Evaluation Criteria for Effectiveness

The effectiveness of actions taken, and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation and evaluation of initiatives to:

- Report, monitor and trend outcomes.
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines.
- Support efforts to improve internal and external customer satisfaction.

- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement.
- Coordinate and communicate organizational information, both division and department specific, and agency-wide.
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews.
- Facilitate satisfaction surveys for members and practitioners.
- Provide agency-wide oversight of monitoring activities that are:

  Balanced: Measures clinical quality of care and customer service
  Comprehensive: Monitors all aspects of the delivery system
  Positive: Provides incentive to continuously improve

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction surveys
- QI Projects: Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement CCIP)
- Health Risk Assessment (HRA) data

By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data) the data warehouse can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARS and HOS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, and MBHOs, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality measure) is accompanied by clear guidelines for interpretation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined

- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population.
- Description of data sources and evaluation of their accuracy and completeness.
- Description of sampling methodology and methods for obtaining data.
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome.
- Baseline data collection and analysis timelines.
- Data abstraction tools and guidelines.
- Documentation of training for chart abstraction.
- Rater to standard validation review results.
- Measurable objectives for each quality measure.
- Description of all interventions including timelines and responsibility.
- Description of benchmarks.
- Re-measurement sampling, data sources, data collection, and analysis timelines.
- Evaluation of re-measurement performance on each quality measure.

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between healthcare 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 and Behavioral Health Services areas.

Health Promotion

Health Education provides program development and implementation for agency-wide population health programs**.** PHM programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management and Tobacco Cessation.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provides a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner and CalOptima. PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources, and support to members as they learn to care for themselves and their condition. The PHM program also identifies those members in need of closer management, coordination and

intervention. CalOptima assumes responsibility for the PHM program for all of its lines of business, however members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data.
- Documented process to assess the needs of member population.
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory.
- Ability of member to opt-out.
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education and member incentive programs.
- Use of evidenced- based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD).
- Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary.
- Coordinating services for members for appropriate levels of care and resources.
- Documenting all findings.
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services.
- Ongoing assessment of outcomes.

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-term care manager.

The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an ICP
      - Communication with members or their representatives, vendors, and medical group
      - Review and update the ICP at least annually, and when there is a change in the member's health status
      - Referral to the primary ICT, as needed

- ICT for Moderate to High-Risk Members — ICT occurs at the HN or Health Plan for Community Network
  - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Case management of high-risk members
      - Coordination of ICPs for high risk members
      - Facilitating member, PCP and specialists, and vendor communication
      - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization.
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals.
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning.

Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home and Community Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

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

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger 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) 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 utilization management, claims, credentialing the provider network, member services, and quality improvement.

OC and OCC
CalOptima has contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Functions delegated to Magellan include provider network, UM, credentialing, and customer service.

CalOptima OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a Magellan representative for behavioral health assistance. If office-based services are appropriate, the member is registered and given referrals to an appropriate provider. If ambulatory Specialty Mental Health needs are identified, services may be rendered through the Orange County Mental Health Plan.

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

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those which are established as safe and effective, consistent with symptoms and

diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2018 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff reviews and approves requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2019 UM Program Description and related Work Plan.

ENTERPRISE ANALYTICS

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and roadmap for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the roadmap. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services and Medical Affairs, the EA team develops or extends the data architecture and data definitions which expresses a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions, and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery, and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally and include strategic efforts specific to member safety.

This safety program is based on a needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations

- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Group needs assessment
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including CBAS, SNF, and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications

    - Sentinel events, critical incident identification, appropriate investigation and remedial action
    - Administration of flu and pneumonia vaccines
- Administrative offices
    - Fire, disaster, and evacuation plan, testing and annual training

CULTURAL & LINGUISTIC SERVICES

CalOptima serves a large and culturally diverse population. The seven most common languages spoken for all CalOptima programs are: English 56%, Spanish 28%, Vietnamese 11%, Farsi 1%, Korean 1%, Chinese 1%, Arabic 1% and all others at 3%, combined. CalOptima provides member materials in:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic
- OC member materials are provided in three languages: English, Spanish and Vietnamese
- OCC member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. See CalOptima Policy DD. 2002 — Cultural and Linguistic Services for a detailed description of the program.

Objectives for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas.
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved.
- Considering outcomes of member grievances and complaints.
- Conducting patient-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks.
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group.
- Providing information, training and tools to staff and practitioners to support culturally competent communication.

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to HMO, PHC, SRG, and MBHO contractors who are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services.
- QI program for all lines of business, HMOs, PHCs, SRGs, and MBHOs must comply with all quality related operational, regulatory and accreditation standards.
- Medi-Cal Behavioral Health.
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program.
- Health Education (as applicable).
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases.
- Development of system-wide measures, thresholds and standards.
- Satisfaction surveys of members, practitioners and providers.
- Survey for Annual Access and Availability.
- Access and availability oversight and monitoring.
- Second level review of provider grievances.
- Development of credentialing and re-credentialing standards for both practitioners and health care delivery organizations (HDOs).
- Credentialing and re-credentialing of HDOs.
- Development of UM and Case Management standards.
- Development of QI standards.
- Management of Perinatal Support Services (PSS).
- Risk management.
- Pharmacy and drug utilization review as it relates to quality of care.
- Interfacing with State and Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2018 Delegation Grid.

See Appendix B — 2019 Delegation Grid

IN SUMMARY

As stated earlier, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

Appendix A — 2019 QI Work Plan

Appendix B — 2019 Delegation Grid

Appendix C — 2019 PHM Strategy

2019 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

A. 2019 QI Annual Oversight of Program and Work Plan
B. 2018 QI Program Evaluation
C. 2019 UM Program
D. 2018 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee Oversight
G. BHQIC Oversight
H. UMC Oversight
I. Member Experience SubCommittee Oversight
J. LTSS QISC Oversight
K. Whole Child Model - Clinical Advisory Committee
L. GARS Committee
M. PACE QIC
N. Quality Program Oversight - Quality Withold
O. Quality Program Oversight - QIPE/PPME Monitoring for OC/OCC

INITIAL WORK PLAN AND APPROVAL:
Submitted and approved by QIC: Date: 1/8/2019
Submitted and approved by QAC: Date:
Submitted and approved by Board of Director's Date:

Quality Improvement Committee Chairperson:

David Ramirez, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, MD Date:

II. QUALITY OF CLINICAL CARE- ADULT HEALTH- MENTAL

A. Antidepressant Medication Management (AMM): Continuation Phase Treatment
B. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

III. QUALITY OF CLINICAL CARE - ADULT HEALTH-PHYSICAL

A. Statin Use in Persons with Diabetes (SUPD)
B. Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
C. Use of Imaging Studies for Lower Back Pain (LBP)
D. Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)
E. Cervical Cancer Screening (CCS)
F. Colorectal Cancer Screening (COL)
G. Breast Cancer Screening (BCS)
H. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

IV. QUALITY OF CLINICAL CARE - CHILD/ADOLECENT HEALTH

A. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase
B. Depression Screening and Follow-Up for Adolescents (DSF)
C. Childhood Immunization Status (CIS): Combo 10
D. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)
E. Well-Care Visits in first 15 months of life (W15)

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F. Adolescent Well-Care Visits (AWC)
G. Appropriate Testing for Children with Pharyngitis (CWP)
H. Children and Adolescents' Access to Primary Care (CAP)

V. QUALITY OF CLINICAL CARE - CHRONIC CONDITIONS

A. Improve HEDIS measures related to Asthma (AMR)
B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Including HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention to Nephrology

VI. QUALITY OF CLINICAL CARE - COORDINATION OF CARE

A. Plan All-Cause Readmissions (PCR)

VII. QUALITY OF CLINICAL CARE - MATERNAL CHILD HEATH

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum

VIII. QUALITY OF CLINICAL CARE

A. Improving the quality performance of all HNs, including CalOptima Community Network (CCN).

IX. QUALITY OF SERVICE

A Review and Report GARS for all Lines of Business, Include review of quality issues (QOC, QOS, Access) related to member experience.

X. SAFETY OF CLINICAL CARE

A. Use of Opiods at High Dosage (UOD)
B. Use of Opioids from Multiple Providers (UOP)
C. Follow-up on Potential Quality Of Care Complaints

XI. MEMBER EXPERIENCE

A. Review of Member Experience (CAHPS)
-Increase CAHPS score on Getting Needed Care
B. Review of Member Experience (CAHPS)
-Increase CAHPS score on Getting Care Quickly
C. Review of Member Experience (CAHPS)
-Increase CAHPS score on How Well Dr Communication
D. Review of Member Experience (CAHPS)
-Increase CAHPS score on Care Coordination

XII. COMPLIANCE

A. Delegation Oversight of HN Compliance (UM, CR, Claims)
B. HN Compliance with CCM NCQA Standards

Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
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	Quality Improvement	QIC
Program Oversight		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	Quality Improvement	QIC
Program Oversight		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	Utilization Management	QIC
Program Oversight		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	Utilization Management	QIC
Program Oversight		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	Quality & Population Health Management	QIC
Program Oversight		**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	Quality Improvement	QIC
Program Oversight		**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	Behavioral Health	QIC
Program Oversight		**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	Frank Federico MD/ Tracy Hitzeman	Utilization Management	QIC
Program Oversight		**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	Quality Analytics	QIC
Program Oversight		**Long Term Services and Supports Quality Improvement Sub-Committee (LTSS-QISC) Oversight** - Conduct Internal and External oversight of LTSS QI Activities per regulatory and contract requirement	Monitor and review the quality and outcomes of services provided to members in both Nursing Facility Services for Long-Term Care and Home and Community Based Services.	The LTSS Quality Improvement Sub Committee meets on a quarterly basis and addresses key components of regulatory, safety, quality and clinical initiatives.	Quarterly Adoption of Report	Emily Fonda, MD/ Steven Chang	LTSS	QIC
Program Oversight		**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	Medical Affairs	QIC
Program Oversight		**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	QIC
Program Oversight		**PACE QIC** - Quarterly review and update of PACE QIC activities	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 summarized quarterly at QIC	Quarterly Adoption of Report	Miles Masatsugu, MD	PACE	QIC

Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Program Oversight		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/ Tracy Hitzeman	Quality & Analytics	QIC
Program Oversight		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	As specified on dashboard	Tracy Hitzeman/ Betsy Ha	Medical Affairs	QIC
Quality of Clinical Care	Adult Health - Mental	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	Create report of new members in measure Outreach to these members to assess barriers to adherence Provider Incentives for improvement above baseline rate Provider Training and Education	12/31/2019	Edwin Poon	Behavioral Health	BHQIC
Quality of Clinical Care	Adult Health - Mental	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	Behavioral Health	BHQIC
Quality of Clinical Care	Adult Health - Physical	Statin Use in Persons with Diabetes (SUPD)	Therapy OC:74% 66th percentile OCC:74% 66th percentile Adherence OC: 80.75% 75th percentile OCC: 74.56% 50th percentile	Provider Incentives Practice Transformation Initiative (PTI) Member Incentives Provider Report Card Provider Training and Education Academic Detailing	12/31/2019	Nicki Ghazanfarpour Pshyra Jones	Pharmacy	QIC
Quality of Clinical Care	Adult Health - Physical	Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	MC: 79.67% 50th percentile OC: N/A OCC: 90.23% 50th percentile	Provider Incentives Align case management post discharge outreach (create workflow in GC) DM/CM/Pharmacy followup after 6 months Provider Report Card	12/31/2019	Nicki Ghazanfarpour	Pharmacy	QIC

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Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Quality of Clinical Care	Adult Health - Physical	Use of Imaging Studies for Lower Back Pain (LBP)	MC: 71.71% 50th percentile	Move spine x-rays to auth required list (all networks). For CCN: Offer DME in home PT assessments as an option for providers or UM to order (would need guidelines). Auto-approve PT for CCN. Ask about exclusions on auth request form (CCN). Outreach to requesting providers to request documentation of exclusions. Provider Report Card.	12/31/2019	Tracy Hitzeman	Utilization Management	QIC
Quality of Clinical Care	Adult Health - Physical	Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	MC: 75.84% 25th percentile	Pay for Value Continue implementing MC PIP activities through 6/30/2019 Member Incentives Lists of members: no visits after 6 and 9 months, no visits over multiple years; Send list to PCP's Provider Incentives	6/30/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Adult Health - Physical	Cervical Cancer Screening (CCS)	MC: 63.26% 66th percentile	Member Incentives Pay for Value UCI Quality Initiative to improve cancer screening targeting Asian American	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Adult Health - Physical	Colorectal Cancer Screening (COL)	OC: 4 STAR OCC: 3 STAR	Pay for Value Member Incentives Possible opportunities for FOBT test kits UCI Quality Initiative to improve cancer screening targeting Asian American For CCN: Update Auto-approval rules UM MA call members with approved auths to offer to schedule appointments	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Adult Health - Physical	Breast Cancer Screening (BCS)	MC: 65.30% 75th percentile	Pay for Value Member Incentives Conduct Mobile Mammography events for CCN members UCI Quality Initiative to improve cancer screening targeting Asian American CCN: Auto-Approve screening requests and send letter and/or call members if auth approved	12/31/2019	Mimi Cheung	Quality Analytics	QIC

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Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Quality of Clinical Care	Adult Health - Physical	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	MC; 27.63% 25th percentile	Pay for Value Urgent Care Center Provider Incentives	12/31/2019	Pshyra Jones/ Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	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	Provider Report Card Virtual Care/Texting Members Pharmacist Outreach Provider Incentives	12/31/2019	Edwin Poon	Behavioral Health	BHQIC
Quality of Clinical Care	Child/Adolescent Health	Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)	New in 2019, DHCS required, for MC, no external benchmarks	Continue depression screening incentive through May 2019 Expand provider incentive to kids 12 and older	5/31/2019	Edwin Poon	Behavioral Health	BHQIC
Quality of Clinical Care	Child/Adolescent Health	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%	Pay for Value Implement CalOptima Days (with Member and Provider Incentive) Practice Transformation Initiative	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	MC: 83.70% 90th percentile	Pay for Value Implement CalOptima Days (with Member and Provider Incentives) Practice Transformation Initiative	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Well-Care Visits in first 15 months of life (W15)	MC: 58.54% 25th percentile	Pay for Value Implement CalOptima Days (with Member and Provider Incentives) Practice Transformation Initiative Bright Steps Program Implementation	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Adolescent Well-Care Visits (AWC)	MC: 54.57% 50th percentile	Pay for Value Implement CalOptima Days (with Member and Provider Incentives) Practice Transformation Initiative	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Child/Adolescent Health	Appropriate Testing for Children with Pharyngitis (CWP)	MC: 72.52% 25th percentile	Pay for Value Target urgent care centers and high volume provider offices. Distribute pharyngitis kits to targeted offices. Provider Report Card Urgent Care Center Provider Incentives Offer provider incentive for administering the test and documenting appropriately.	12/31/2019	Mimi Cheung	Quality Analytics	QIC

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Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Quality of Clinical Care	Child/Adolescent Health	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	Pay for Value (12-19 years only) Implement CalOptima Days (with Member and Provider Incentives)	12/31/2019	Mimi Cheung	Quality Analytics	QIC
Quality of Clinical Care	Chronic Conditions	Improve HEDIS measures related to Asthma: Asthma Medication Ratio (AMR)	MC: 65.30% 66th percentile	Pay for Value Member Incentives Identify high risk patients (ratio < 0.5 and/or exacerbation coded); Outreach to educate members and offer pulmonology referrals; Identify providers with low scores and educate/train and/or offer pharmacists to help them manage their asthma patients; Contract with vendor for home RT assessments and recommendations.	12/31/2019	Pshyra Jones	Population Health Mgmt.	QIC
Quality of Clinical Care	Chronic Conditions	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	Pay for Value Diabetes Bundle Provider Incentives Member incentives	12/31/2019	Pshyra Jones/ Dr. Dajee	Population Health Mgmt.	QIC
Quality of Clinical Care	Chronic Conditions	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	Pay for Value Diabetes Bundle Provider Incentives Member incentives	12/31/2019	Pshyra Jones/ Dr. Dajee	Population Health Mgmt.	QIC
Quality of Clinical Care	Chronic Conditions	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	Pay for Value Diabetes Bundle Provider Incentives Member incentives	12/31/2019	Pshyra Jones/ Dr. Dajee	Population Health Mgmt.	QIC
Quality of Clinical Care	Chronic Conditions	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	Pay for Value Diabetes Bundle Provider Incentives Member incentives	12/31/2019	Pshyra Jones/ Dr. Dajee	Population Health Mgmt.	QIC

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Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
Quality of Clinical Care	Coordination of Care	Plan All-Cause Readmissions (PCR)	MC: N/A OC: 8% 50th percentile OCC: 10%	Update Transition of Care post-discharge program Obtain real time ER data	12/31/2019	Sloane Petrillo	Case Management	QIC
Quality of Clinical Care	Maternal Child Health	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	Prenatal: 87.06% 75th percentile	Bright Steps Program Implementation Provider Incentives Member Incentives	12/31/2019	Pshyra Jones/ Ann Mino	Population Health Mgmt.	QIC
Quality of Clinical Care	Maternal Child Health	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	Postpartum: 73.97% 90th percentile	Bright Steps Program Implementation Provider Incentives Member Incentives	12/31/2019	Pshyra Jones/ Ann Mino	Population Health Mgmt.	QIC
Quality of Clinical Care		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 all 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	Marsha Choo / Esther Okajima	Quality Analytics	QIC
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	Ana Aranda	GARS	MEMX
Safety of Clinical Care		Use of Opioids at High Dosage (UOD)	New in 2019, Need to establish benchmark and goals	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics Prescriber monitoring and education	12/31/2019	Kris Gericke	Pharmacy	UMC
Safety of Clinical Care		Use of Opioids from Multiple Providers (UOP)	New in 2019, Need Goals	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics Prescriber monitoring and education	12/31/2019	Kris Gericke	Pharmacy	UMC
Safety of Clinical Care		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	Esther Okajima/ Laura Guest	Quality Improvement	CPRC

Evaluation Category	Evaluation Sub-category	2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Department	Report to Committee
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	Pay for Value Incentives for providers in select difficult to access specialties CalOptima Days for Specialists Virtual Care Streamline CCN prior auth process	12/31/2019	Kelly Rex-Kimmet/ Marsha Choo	Quality Analytics	MEMX
Member Experience		Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Care Quickly	Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	Pay for Value Incentives for providers in select difficult to access specialties CalOptima Days for Specialists Virtual Care Streamline CCN prior auth process	12/31/2019	Kelly Rex-Kimmet/ Marsha Choo	Quality Analytics	MEMX
Member Experience		Review of Member Experience (CAHPS)-Increase CAHPS score on How Well Dr Communication	Improve Member Experience for **How Well Drs Communicate** from 25th to 50th percentile	Pay for Value Provider Coaching Practice Transformation Initiative Health Literacy Training	12/31/2019	Kelly Rex-Kimmet/ Marsha Choo	Quality Analytics	MEMX
Member Experience		Review of Member Experience (CAHPS)-Increase CAHPS score on Care Coordination	Improve Member Experience for **Care Coordination** from 25th to 50th percentile	Pay for Value Practice Transformation Initiative	12/31/2019	Sloane Petrillo	Medical Affairs	MEMX
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	A&O	AOC
Compliance		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	Case Management	AOC

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
QI1A: QI Program Structure	X		X		CO responsibility S&P component, even if delegated
QI1B: Annual Evaluation	X		X		CO responsibility S&P component, even if delegated
QI2A: QI Committee Responsibilities	X		X		CO responsibility S&P component, even if delegated
QI2B: Informing Members	X		X		CO responsibility S&P component, even if delegated
QI3A: Practitioner Contracts	X		X		CO responsibility S&P component, even if delegated
QI3B: Affirmative Statement	X		X		CO responsibility S&P component, even if delegated
QI3C: Provider Contracts	X		X		CO responsibility S&P component, even if delegated
QI4A: Member Services Telephone Access	X	X	X		
QI4B: BH Telephone Access Standards	X		X		CO responsibility S&P component, even if delegated
QI4C: Annual Assessment-Member Experience	X				CO fields CAHPS, Kaiser complaint data included
QI4D: Opportunities for Improvement-Member Experience	X				
QI4E: Annual Assessment of BH and Services-Member Experience	X		X		Kaiser: Factor1 & Factor2
QI4F: BH Opportunities for Improvement-Member Experience	X				

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; RR – Member Rights & Responsibilities; MEM – Member Connections; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on standards or elements.

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
QI4G: Assessing Experience with the UM Process-Member Experience	X				CO utilizes Kaiser data
QI5A: Identifying Opportunities-Continuity & Coordination of Care (C&C)	X		X		
QI5B: Acting on Opportunities-C&C	X		X		
QI5C: Measuring Effectiveness-C&C	X		X		
QI5D: Transition to other Care-C&C	X	X	X		
QI6A: Data Collection- C&C Behavioral Health	X		X		
QI6B: Collaborative Activities- C&C Behavioral Health	X		X		
QI6C: Measuring Effectiveness- C&C Behavioral Health	X		X		
PHM1A: Strategy Description-PHM	X		X		(new) CO responsibility S&P component, even if delegated
PHM1B: Informing Members-PHM	X		X		(new)
PHM2A: Data Integration-PHM	X		X		(new)
PHM2B: Population Assessment-PHM	X		X		(new)

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
PHM2C: Activities and Resources-PHM	X		X		(new)
PHM2D: Segmentation-PHM	X		X		(new)
PHM3A: Practitioner or Provider Support	X		X		(new)
PHM3B: Value-Based Payment Arrangement	X		X		(new)
PHM4A: Health Appraisal (HA) Components	X		X		
PHM4B: HA Disclosure	X		X		
PHM4C: HA Scope	X		X		
PHM4D: HA Results	X		X		
PHM4E: HA Formats	X		X		
PHM4F: Frequency of HA Completion	X		X		
PHM4G: Review and Update Process	X		X		
PHM4H: Topics of Self- Management Tools	X		X		
PHM4I: Usability Testing of Self-Management Tools	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
PHM4J: Review and Update Process for Self-Management Tools	X		X		
PHM4K: Self- Management Tool Formats	X		X		
PHM5A: Access to Case Management-CCM	X	X	X		
PHM5B: Case Management Systems-CCM	X	X	X		
PHM5C: Case Management Process-CCM	X	X	X		CO responsibility S&P component, even if delegated
PHM5D: Initial Assessment-CCM	X	X	X		
PHM5E: Case Management- Ongoing Management-CCM	X	X	X		
PHM5F: Experience with Case Management-CCM	X				
PHM6A: Measuring Effectiveness-PHM	X		X		(new) CO responsibility S&P component, even if delegated
PHM6B: Improvement and Action -PHM	X		X		(new) CO responsibility S&P component, even if delegated
NET1A: Cultural Needs and Preferences	X		X		
NET1B: Practitioners Providing Primary Care	X				CO responsibility S&P component Factors 1&2, even if delegated

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
NET1C: Practitioners Providing Specialty Care	X				CO responsibility S&P component Factors 1-4, even if delegated
NET1D: Practitioners Providing Behavioral Health (BH)	X		X		CO responsibility S&P component Factors 1-3, even if delegated. Factor 4 Kaiser (need to confirm with Marsha)
NET2A: Access to Primary Care	X		X		CO responsibility S&P component, even if delegated
NET2B: Access to BH	X		X		CO responsibility S&P component, even if delegated
NET2C: Access to Specialty Care	X		X		
NET3A: Assessment of Member Experience Accessing the Network	X		X		Kaiser Factor 1&2, factor 3 is new.
NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X		Kaiser Factor 1&2, factor 3 is new.
NET3C: Opportunities to Improve Access to BH Services	X		X		Kaiser Factor 1&2, factor 3 is new.
NET5A: Notification of Termination	X	X	X		
NET5B: Continued Access to Practitioners	X	X	X		
NET6A: Physician Directory Data	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
NET6B: Physician Directory Updates	X		X		
NET6C: Assessment of Physician Directory Accuracy	X		X		
NET6D: Identifying and Acting on Opportunities	X		X		
NET6E: Physician Information Transparency	X		X		
NET6F: Searchable Physician Web-Based Directory	X		X		
NET6G: Hospital Directory Data	X		X		
NET6H: Hospital Directory Updates	X		X		
NET6I: Hospital Information Transparency	X		X		
NET6J: Searchable Hospital Web-Based Directory	X		X		
NET6K: Usability Testing	X		X		
NET6L: Availability of Directories	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM1A: Written Program Description	X		X		CO responsibility S&P component, even if delegated
UM1B: Physician Involvement	X		X		CO responsibility S&P component, even if delegated
UM1C: BH Practitioner Involvement	X		X		CO responsibility S&P component, even if delegated
UM1D: Annual Evaluation	X		X		CO responsibility S&P component, even if delegated
UM2A: UM Criteria	X	X	X		CO responsibility S&P component, even if delegated
UM2B: Availability of Criteria	X	X	X		
UM2C: Consistency in Applying Criteria	X	X	X	X	
UM3A: Access to Staff	X	X	X		
UM4A: Licensed Health Professionals	X	X	X	X	CO responsibility S&P component, even if delegated
UM4B: Use of Practitioners for UM Decisions	X	X	X	X	CO responsibility S&P component, even if delegated
UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X		
UM4D: Practitioner Review of BH Denials	X		X		
UM4E: Practitioner Review of Pharmacy Denials	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM4F: Use of Board-Certified Consultants	X	X	X		
UM4G: Affirmative Statement About Incentives	X	X	X		
UM5A: Timeliness of Non-Behavioral UM Decision Making	X	X	X		
UM5B: Notification of Non-Behavioral Decisions	X	X	X		
UM5C: Timeliness of Behavioral Healthcare UM Decision Making	X		X		
UM5D: Notification of Behavioral Healthcare Decisions	X		X		
UM5E: Timeliness of Pharmacy UM Decision Making	X		X	X	
UM5F: Notification of Pharmacy Decisions	X		X	X	
UM5G: UM Timeliness Report	X	X	X	X	HN Factor1, 2; Med Impact Factor 5; CO Factor 3, 4, 6
UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X		
UM6B: Relevant Information for BH Decisions	X		X		
UM6C: Relevant Information for Pharmacy Decisions	X		X		
UM7A: Discussing a Denial with a Reviewer	X	X	X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X		
UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X		
UM7D: Discussing a BH Denial with a Reviewer	X		X		
UM7E: Written Notification of BH Denials	X		X		
UM7F: BH Notice of Appeal Rights/Process	X		X		
UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X		
UM7H: Written Notification of Pharmacy Denials	X		X	X	
UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	X	
UM8A: Internal Appeals (Policies and Procedures)	X		X		CO responsibility S&P component, even if delegated
UM9A: Pre-service and Post-service Appeals	X		X		
UM9B: Timeliness of the Appeal Process	X		X		
UM9C: Appeal Reviewers	X		X		
UM9D: Notification of Appeal Decision/Rights	X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; RR – Member Rights & Responsibilities; MEM – Member Connections; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on standards or elements.

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X		
UM11B: Pharmaceutical Restrictions/Preferences	X		X		
UM11C: Pharmaceutical Patient Safety Issues	X		X		
UM11D: Reviewing and Updating Procedures	X		X		
UM11E: Considering Exceptions	X		X		
CR1A: Practitioner Credentialing Guidelines	X	X	X		CO responsibility S&P component, even if delegated
CR1B: Practitioner Rights	X	X	X		CO responsibility S&P component, even if delegated
CR2A: Credentialing Committee	X	X	X		
CR3A: Verification of Credentials	X	X	X		
CR3B: Sanction Information	X	X	X		
CR3C: Credentialing Application	X	X	X		
CR4A: Recredentialing Cycle Length	X	X	X		
CR5A: Ongoing Monitoring and Interventions	X	X	X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
CR6A: Actions Against Practitioners	X	X	X		CO responsibility S&P component, even if delegated
CR7A: Review and Approval of Provider	X	X	X		
CR7B: Medical Providers	X	X	X		
CR7D: Assessing Medical Providers	X	X	X		
CR1C: Performance Monitoring for Re-Credentialing (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR1D: Contracts Opt-Out Provisions (CMS)	*X*	*X*	*X*		*CMS Requirement*
CR1E: Medicare-Exclusions/Sanctions (CMS)	*X*	*X*	*X*		*CMS Requirement*
CR3D: Hospital Admitting Privileges (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR3E: Facility Site Review (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR3F: Enrollment & Screening (DHCS APL 17-019)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR3G: Review of Performance Information -Recred (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
CR5B: Monitoring Medicare opt Out (CMS)	*X*	*X*	*X*		*CMS Requirement*
CR5C: Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	*X*	*X*	*X*		*DHCS Requirement*

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
CR6B: Appeals Process for Termination/Suspension (CMS)	*X*	*X*	*X*		*CMS Requirement*
CR9A: ID of HIV/AIDS Specialists: Written Process	*X*	*X*	*X*		*DHCS Requirement*
CR9B: ID of HIV/AIDS Specialists: Evidence of Implementation	*X*	*X*	*X*		*DHCS Requirement*
CR9C: ID of HIV/AIDS Specialists: Distribution of Findings	*X*	*X*	*X*		*DHCS Requirement*
RR1A: Rights and Responsibility Statement	X				
RR1B: Distribution of Rights Statement	X				
RR2A: Policies and Procedures for Complaints	X		X		CO responsibility S&P component, even if delegated
RR2B: Policies and Procedures for Appeals	X		X		CO responsibility S&P component, even if delegated
RR3A: Subscriber Information	X				
RR3B: Interpreter Services	X	X	X		
MEM1B: Functionality: Telephone Requests	X	X	X		
MEM2A: Pharmacy Benefit Information: Website	X		X	X	PBM delegate possibility for Factors 6-8
MEM2B: Pharmacy Benefit Information: Telephone	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
MEM2C: QI Process on Accuracy of Information	X		X		
MEM2D: Pharmacy Benefit Updates	X		X		
MEM3A: Functionality: Web Site	X		X		CO: Factors 1-3; Kaiser Factors 1,2,3; Factor4 NA
MEM3B: Functionality: Telephone	X	X	X		
MEM3C: Quality and Accuracy of Information	X	X	X		HN For telephone only
MEM3D: E-Mail Response Evaluation	X		X		
MEM4A: Supportive Technology	X		X		

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CalOptima Population Health Management (PHM) Strategy

PHM Strategy Description [PHM1 A]

BACKGROUND

Who We Are

Orange County is unique in that it does not have county-run hospitals or clinics. CalOptima was created in 1993 by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal (Medicaid) benefits in Orange County, and is the largest COHS nationwide. As a public agency, CalOptima is governed by a Board of Directors with voting members from the medical community, business, county government and a CalOptima member. CalOptima's mission is to provide members with access to high quality health services delivered in a cost-effective and compassionate manner.

CalOptima contracts with the State of California Department of Health Care Services (DHCS) to arrange and pay for covered services to Medi-Cal members, and also contracts with the Centers for Medicare & Medicaid Services (CMS) for Medicare-reletad programs. As of October 2018, CalOptima's total membership is more than 775,000, which includes members in Medi-Cal; a Medicare Advantage SNP; a Cal MediConnect Plan (Medicare-Medicaid); and the Program for All-Inclusive Care for the Elderly (PACE).

Medical services are delivered to CalOptima's Medi-Cal members through a variety of contractual arrangements. As of May 2018, CalOptima contracts with 13 health networks, including four Health Maintenance Organizations (HMOs), three Physician/Hospital Consortia (PHCs) composed of a primary medical group and hospital, and five Shared Risk Medical Groups (SRGs). CalOptima is able to fulfill its mission in Orange County because of its successful partnership with its outstanding providers.

Intent

CalOptima has a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe,

effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

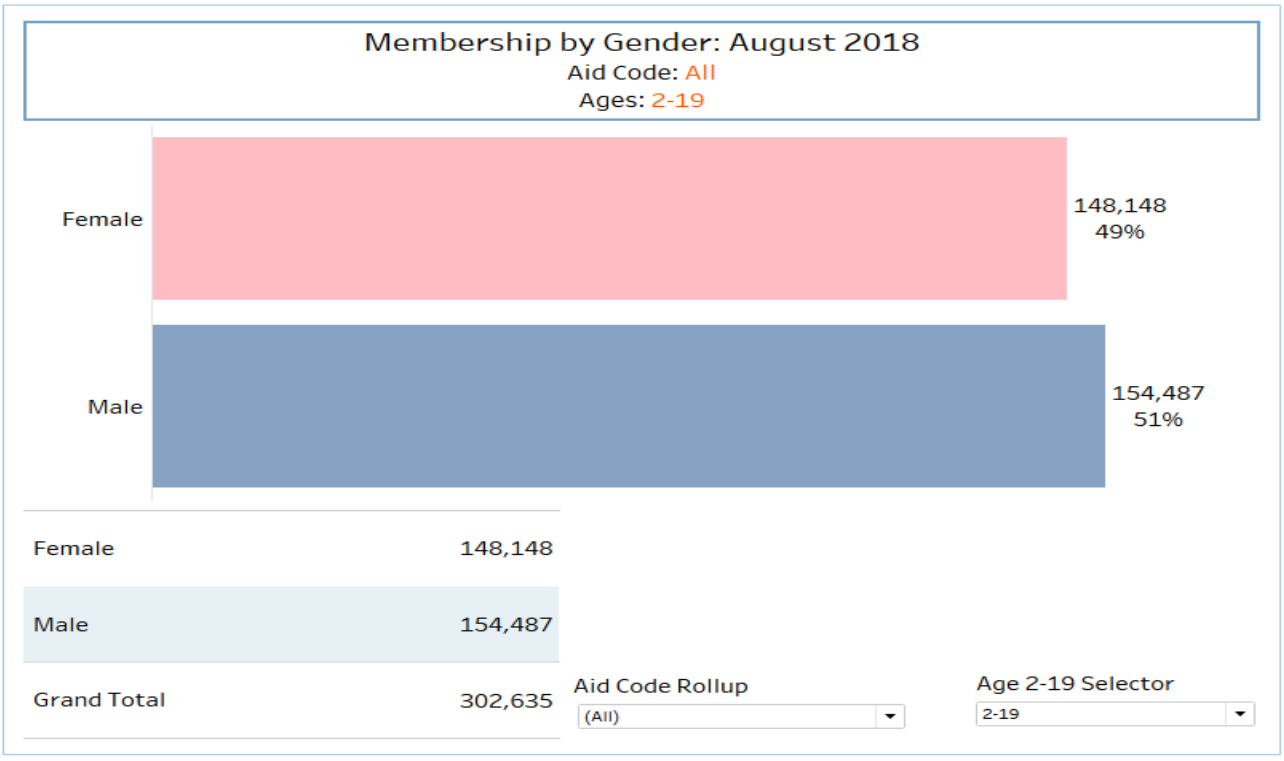
- **CalOptima's Target Population**
  - **Population Identification [PHM2]**
    - CalOptima identifies and assesses its population through a variety of efforts and uses the findings for appropriate interventions. One of many sources that the PHM Strategy is based upon is the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. The PHM plan of action addresses the unique needs and challenges of specific ethnic communities, including economic, social, spiritual, and environmental stressors, to improve health outcomes. The PHM plan of action, as part of the Quality Improvement (QI) Work Plan, is updated annually through the comprehensive annual QI Program Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflects the changing demographics and local population needs of the Orange County community. Since CalOptima members represent 25% of Orange County residents, other examples of external reports used to help identify trends that may impact CalOptima population are identified below.
      - The 2016 Orange County Community Indicators Report
      - The 2017 Conditions of Children in Orange County Report
      - Children eligible for California Children's Services (CCS) Report from the county CCS Program
      - Prenatal Notification Report (PNR)
  - **Data Integration [PHM2 A]**
    - CalOptima integrates multiple internal and external data sources in its data warehouse to support population identification and various PHM functions. Some examples of internal and external data sources are:
      - Member data from the Department of Health Care Services (DHCS)
      - Medical and Behavioral claims from DHCS and Orange County Health Care Agency (OC HCA) Mental Health inpatient claims
      - Encounters data from contracted health networks
      - Pharmacy claims
      - Laboratory claims and results from Quest and LabCorp
      - Other advanced data sources (e.g., member data of homeless status from Illumination Foundation, Regional Center of Orange County, Utilization Management (UM) authorization data, and qualitative data from health appraisals)

- **CalOptima Population and Sub-Population Segments [PHM2 B]**
  - In addition to external data sources, CalOptima leverages Tableau, an enterprise analytic platform, for segmenting and stratifying our membership, including the subsets to which members are assigned (e.g. high-risk pregnancy, multiple inpatient admissions, co-morbid conditions, disabilities, polypharmacy, high risk and high cost cases, transgender population etc.). The Enterprise and Quality Analytics departments provide standard and ad hoc reports specifying the numbers of members in each category and the programs or services for which they are eligible.

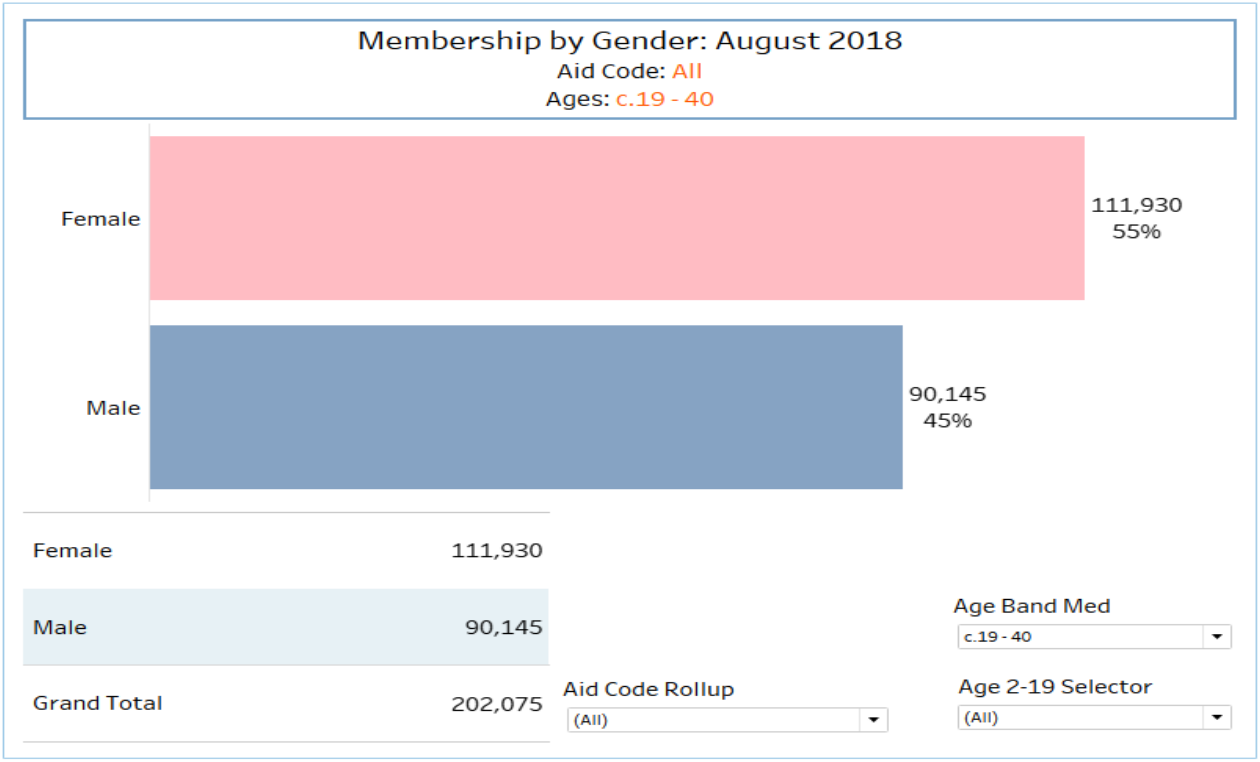
    Example of Member Segmentation – *Source: Tableau_f_dx_v33_m95_08.24.18*

  - *By Age and Gender*

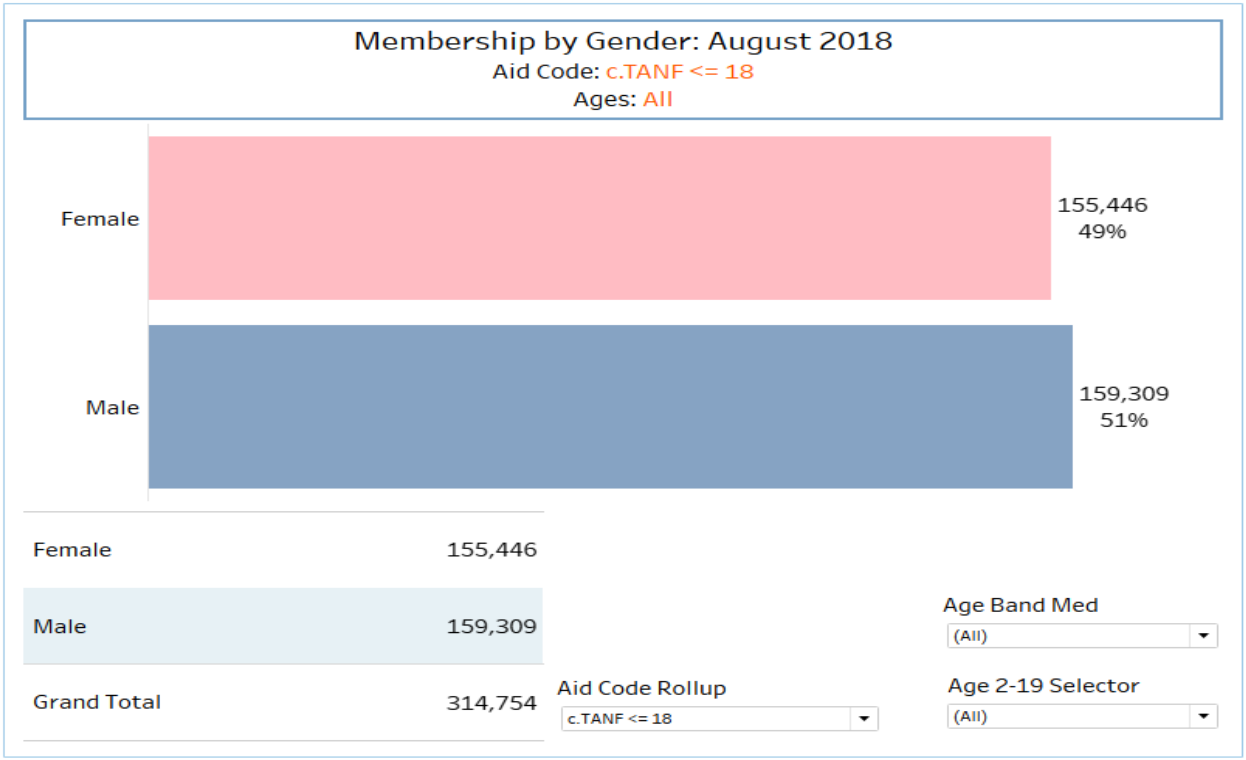
    - *Ages 2–19*



- *Adults 19–40*

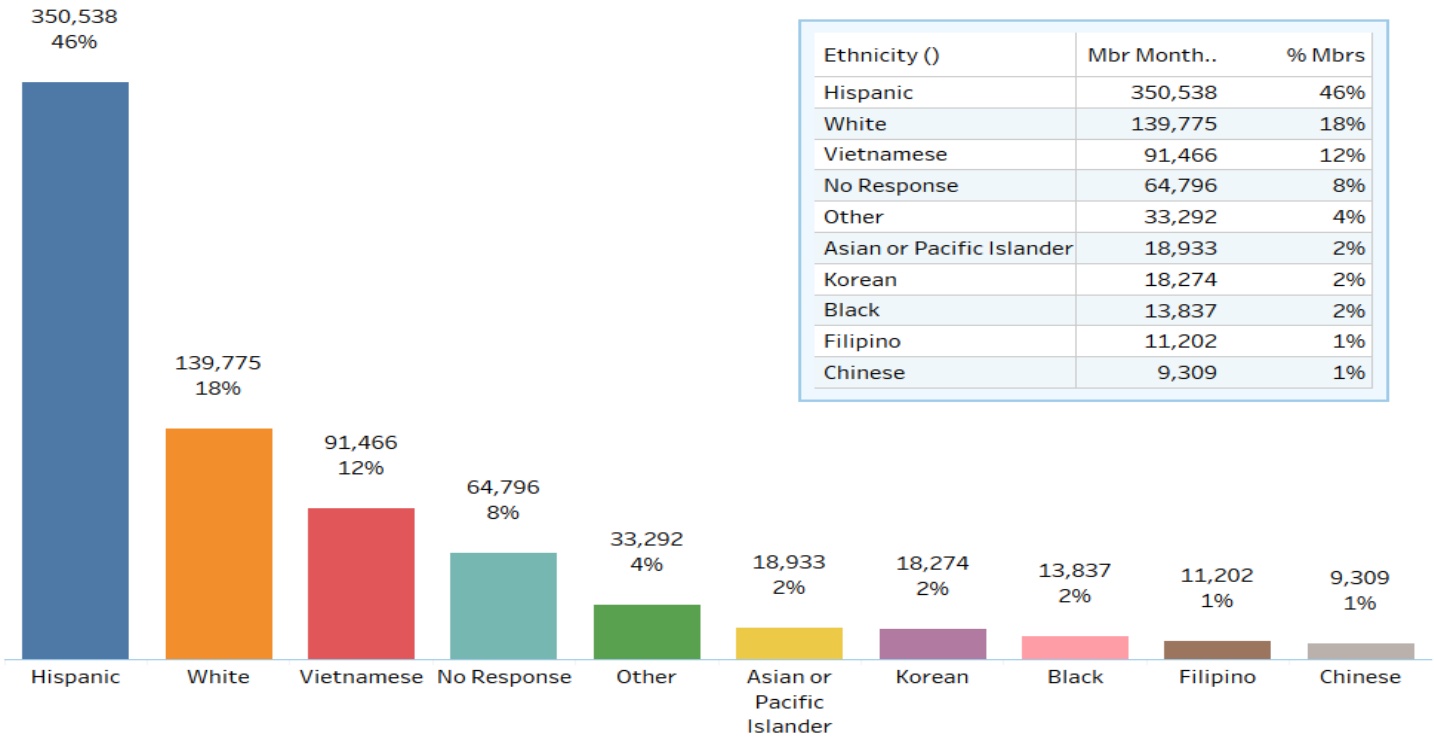


- *TANF (<18 Non-SPD)*



- *Ethnicity*

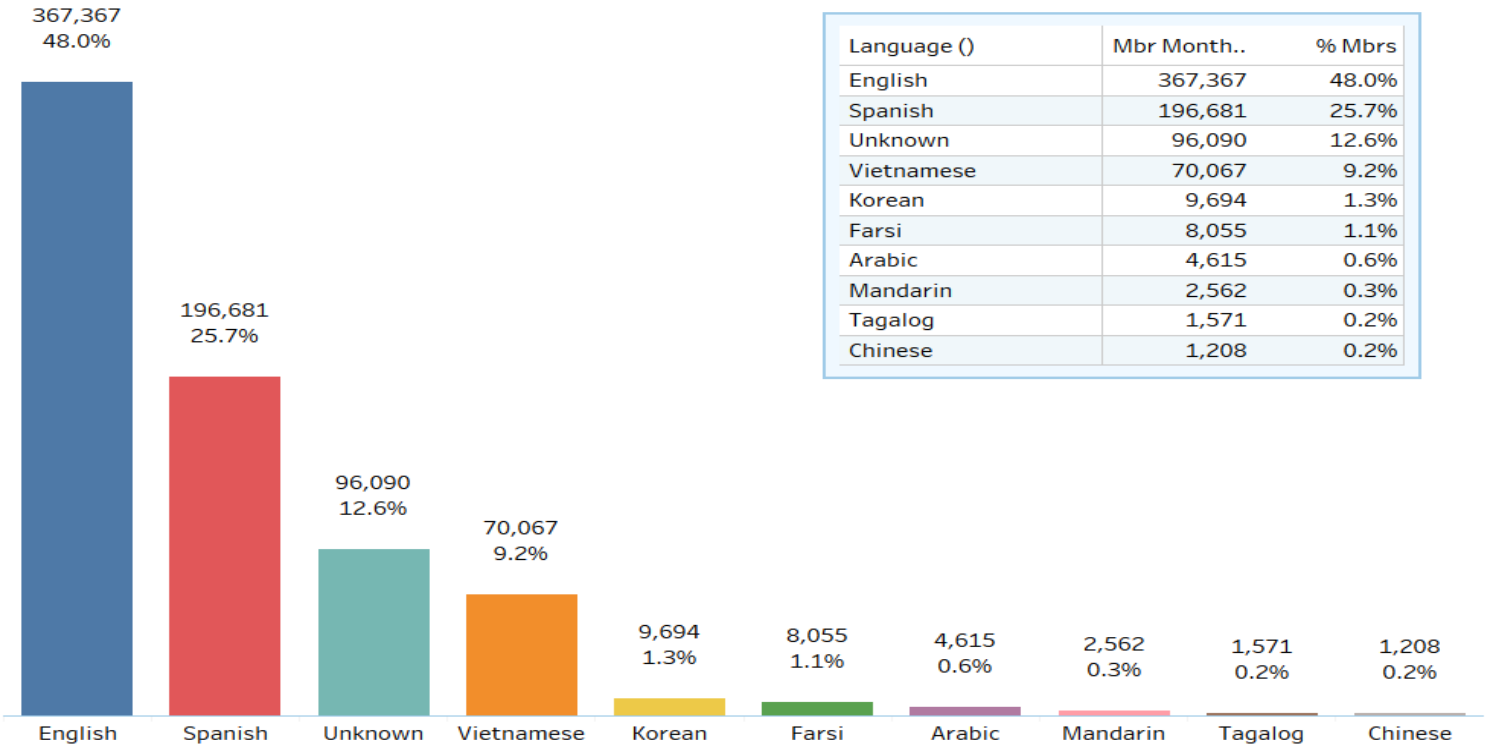
CalOptima Top Ten Member Ethnicities
Aid Code: All
Ages: All
Total Members: 764,774



Ethnicity ()	Mbr Month..	% Mbrs
Hispanic	350,538	46%
White	139,775	18%
Vietnamese	91,466	12%
No Response	64,796	8%
Other	33,292	4%
Asian or Pacific Islander	18,933	2%
Korean	18,274	2%
Black	13,837	2%
Filipino	11,202	1%
Chinese	9,309	1%

- *Language*

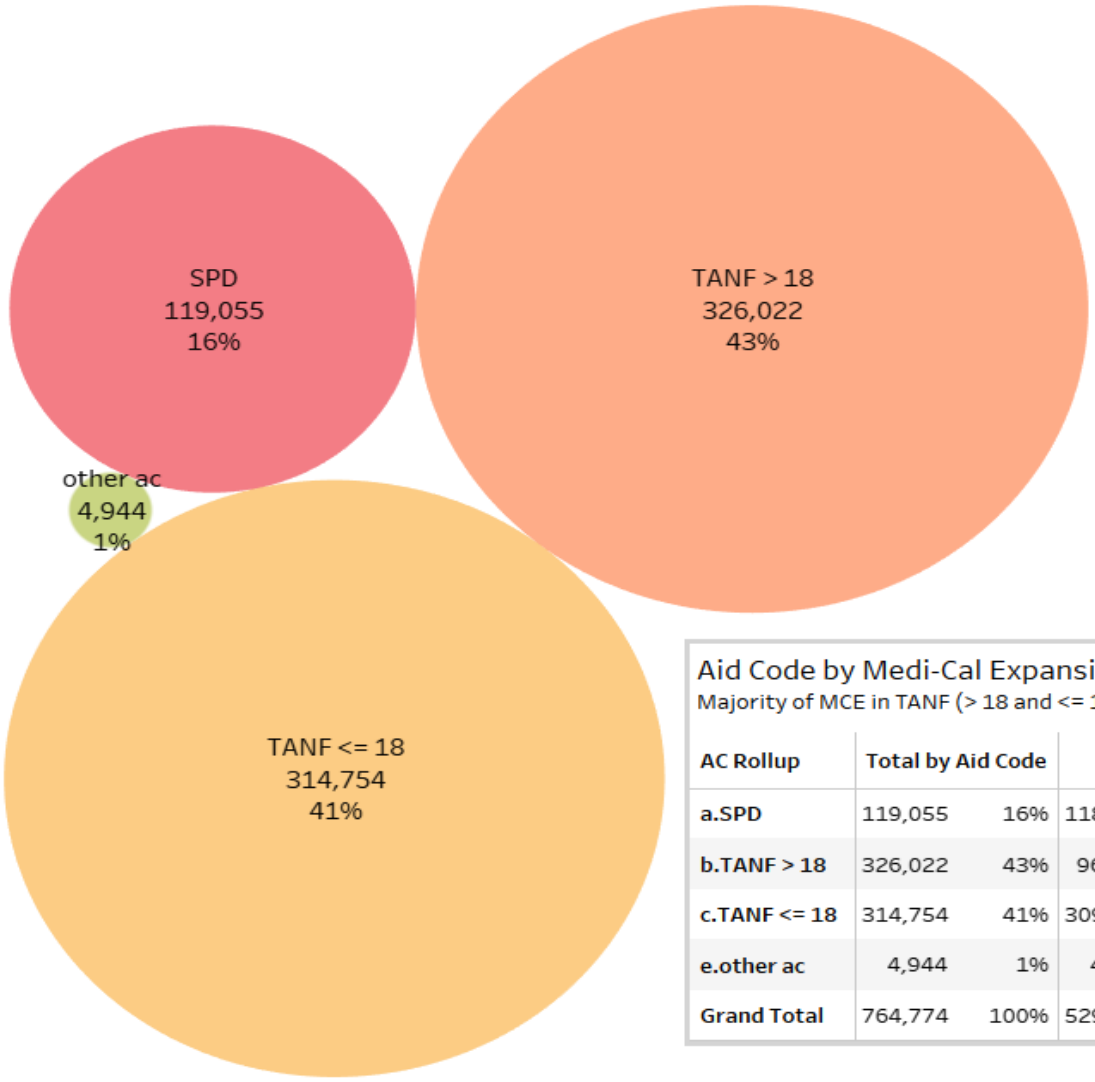
CalOptima Top Ten Member Languages
Aid Code: All
Ages: All
Total Members: 764,774



Language ()	Mbr Month..	% Mbrs
English	367,367	48.0%
Spanish	196,681	25.7%
Unknown	96,090	12.6%
Vietnamese	70,067	9.2%
Korean	9,694	1.3%
Farsi	8,055	1.1%
Arabic	4,615	0.6%
Mandarin	2,562	0.3%
Tagalog	1,571	0.2%
Chinese	1,208	0.2%

- *By Aid Code*

Membership by Aid Code: August 2018

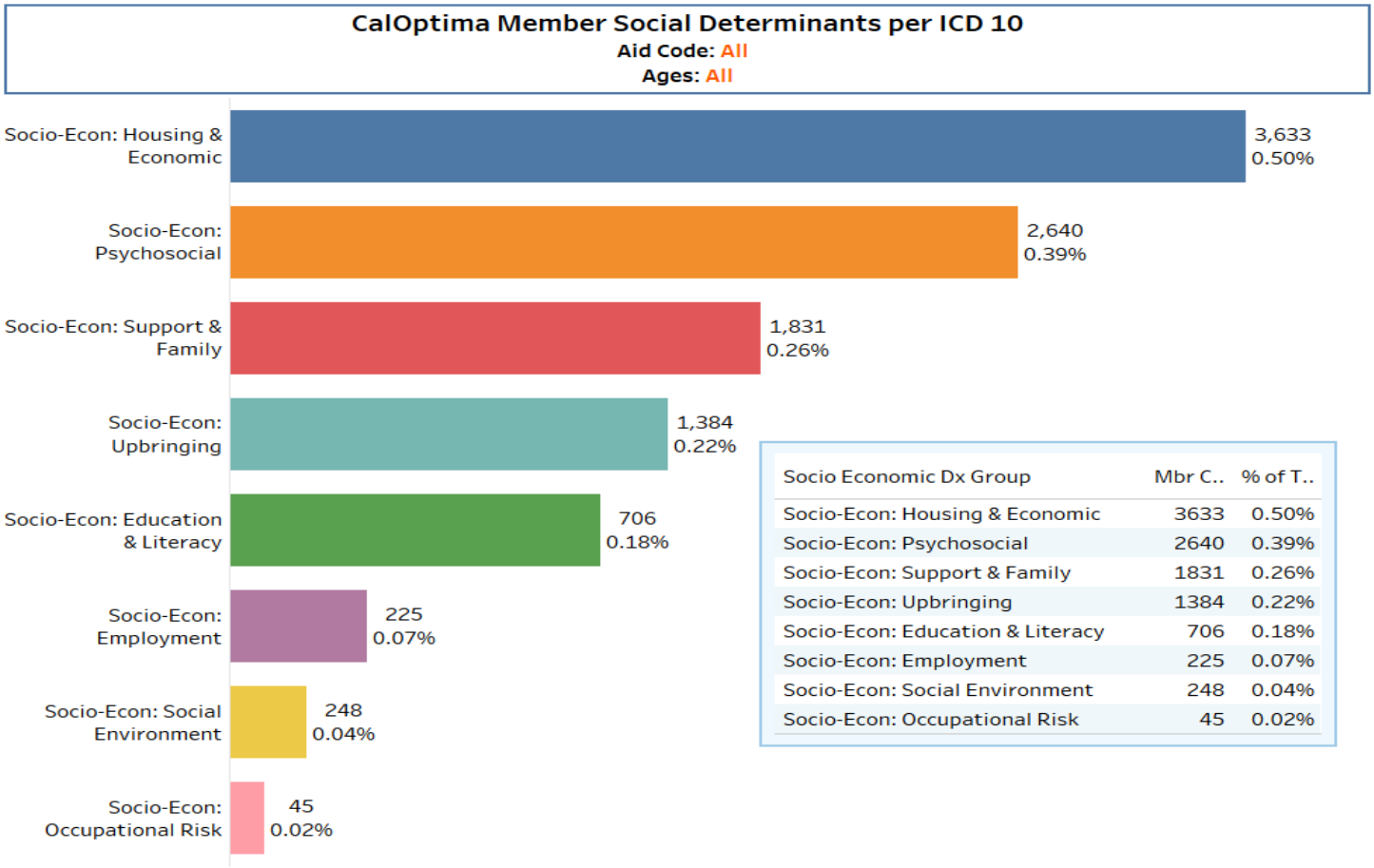


Aid Code by Medi-Cal Expansion (MCE)

Majority of MCE in TANF (> 18 and <= 18) aid codes

AC Rollup	Total by Aid Code		Not MCE		MCE	
a.SPD	119,055	16%	118,657	22%	398	0%
b.TANF > 18	326,022	43%	96,110	18%	229,912	98%
c.TANF <= 18	314,754	41%	309,583	58%	5,171	2%
e.other ac	4,944	1%	4,944	1%		
Grand Total	764,774	100%	529,294	100%	235,481	100%

- *Social Determinants*



Socio Economic Dx Group	Mbr C..	% of T..
Socio-Econ: Housing & Economic	3633	0.50%
Socio-Econ: Psychosocial	2640	0.39%
Socio-Econ: Support & Family	1831	0.26%
Socio-Econ: Upbringing	1384	0.22%
Socio-Econ: Education & Literacy	706	0.18%
Socio-Econ: Employment	225	0.07%
Socio-Econ: Social Environment	248	0.04%
Socio-Econ: Occupational Risk	45	0.02%

➢ **Other Sub-Populations**
- Women during pregnancy
- Children with obesity
- Children with California Children's Services (CCS) eligible condition
- Children and adults with autism
- Adult with disability and chronic conditions
- Persons with substance abuse disorder
- Persons requiring organ transplants
- Person with multiple chronic conditions and homelessness
- Frail elderly adults at risk for institutional care
- Transgender population
- Persons at end of life

❖ **Population Assessment [PHM2 B]**

➢ CalOptima conducts an annual population health risk assessment through analysis of quality performance trends, including Healthcare Effectiveness Data and Information Set (HEDIS) results, member experience surveys in all threshold languages by Health Networks, members complaints and grievances trends, and

inpatient utilization trends. To date, CalOptima serves eligible Medi-Cal beneficiaries from birth to 111 years of age! CalOptima serves a broad spectrum of population with health care needs from the cradle to the grave. Our population segments include well infants, children, adolescents, young adults, pregnant mothers, children with disabilities, children with CCS conditions, well adults, adults with chronic conditions and disabilities, members with serious and persistent mental illness (SPMI), well seniors, frail elderly with deteriorating functional status, and members residing in long-term care (LTC) facilities. The sub-populations include, but are not limited to, populations with health disparities due to race and ethnicity, transgender identity, food insecurity, and homelessness. As the Orange County demographic assessment changes every five years, CalOptima conducts a comprehensive Member Health Needs Assessment of Orange County residents to assess the characteristics and needs of the member population in the community we serve.

2019 PHM STRATEGY

- **Strategies to Keep Members Healthy [PHM1 A Factor 1, 2]**
  - **Bright Steps — Improve Prenatal and Postpartum Care**
    - **Goal:** Demonstrate significant improvement in prenatal and postpartum care rates to achieve 90th percentile by December 2020
      - Improve 2018 HEDIS Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
      - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
    - **Target Population:** Members in the first trimester of pregnancy newly identified through the pregnancy notification form.
    - **Description of Programs or Services:** CalOptima contracts with certified Comprehensive Perinatal Service Program (CPSP) providers to deliver evidenced-based prenatal and postpartum care to members. Bright Steps is designed to support CalOptima Medi-Cal moms through a healthy pregnancy and postpartum care. Annually the program will be evaluated for increased Prenatal and Postpartum Care (PPC) HEDIS rate, reduced rates for neonatal intensive care unit usage, reduced number of low birth weights and preterm births, and member satisfaction with the program.
    - **Activities:** CalOptima staff provide member outreach and coordination with CPSP providers. In areas with limited CPSP providers, CalOptima staff will provide direct health education and support program interventions aligned with the CPSP guidelines.

  - **Shape Your Life — Prevent Childhood Obesity**

- **Goal:** Maintain 2018 HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measures year-over-year
  - BMI Percentile (WCC)
  - Counseling for Nutrition (WCC)
  - Counseling for Physical Activity (WCC)
- **Target Population:** Members age 5-18 with a Body Mass Index (BMI) equal to or above the 85th percentile.
- **Description of Programs or Services:** CalOptima's Shape Your Life health education and physical fitness activity program aims to increase youth member access to weight management program(s), increase doctor/patient communication regarding healthy weight and nutrition and physical activity counseling, and increase member nutrition and physical activity knowledge and improve behaviors. Annually the program will be evaluated for program effectiveness. Measurement goals include pre/post BMI, knowledge gains (pre/post validated survey) and member satisfaction with program.
- **Activities:** The program uses the licensed Kids-N Fitness curriculum which is evidenced-based and validated through Children's Hospital Los Angeles. Interventions includes up to 12 group classes, which include nutrition education and physical activity, and an incentive for a follow up visit with provider after 6 consecutive classes. All classes are conducted in members' community using appropriate threshold language of the participants.

❖ **Strategies to Manage Members with Emerging Risk [PHM1 A Factor 1,2]**

➢ **Health Management Programs — Improving Chronic Illness Care Prevention and Self-Management**

- **Goals:** Develop chronic illness program interventions to support improvements in HEDIS and Member Experience scores
  - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP), and Comprehensive Diabetes Care (CDC)
  - Increase overall Member Satisfaction by improving Rating of All Health Care to 90th Percentile by 2021
  - Reduce ED and IP rates by 3% for program participants in 2018
- **Target population:** Members discovered to be at risk for Asthma, Diabetes and/or Heart Failure based on primary care physician referral, new diagnosis codes, or pharmacy claims. Specific criteria detailed below.

- Members > 3 (Asthma); Members > 18 (Diabetes, Heart Failure) for Medi-Cal, OneCare, and OneCare Connect line of business
- Two year look back period for Asthma, Diabetes, or Heart Failure Related Utilization
- Exclusion Criteria:
  - Ineligible CalOptima Members
  - Members Identified for LTC or diagnosed with Dementia
  - Members Delegated to Kaiser

- **Description of Programs or Services:** CalOptima's Health Management Programs focus on disease prevention and health promotion for members with Asthma, Diabetes and Heart Failure. Health Management Programs are designed to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention. To assess the effectiveness of each Health Management Program, measures are set annually against organization or national benchmark standards. The evaluation takes into consideration program design, methodology, implementation and barriers to provide an analysis with quantitative and qualitative results for CalOptima's population with chronic illness. Measurement goals for each program include improvement in HEDIS measures related to the chronic conditions managed, reduced IP/ED for members with chronic illness, and member satisfaction with health management program.
- **Activities:** Health education using evidence-based clinical practice guidelines and self-management tools, relevant to members for the provision of preventive, acute, or chronic, medical services and behavioral health care services standards and requirements. *(Refer activities list in Policies and Procedures GG.1211.)*

➢ **Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction**

- **Goal:** Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
- **Target Population:** Members with diagnosis of opioid substance abuse disorder
- **Description of Programs or Services:** A multi-departmental and health collaborative aim at reducing opioid misuse and related death.
- **Activities:** Includes, but is not limited to, pharmacy lock-in program, physician academic detailing for safer prescribing, increased access to Medication Assisted Treatment (MAT), and case management outreach.

❖ **Strategies to Ensure Patient Safety [PHM1 A Factor 1,2]**

- **Behavioral Health Treatment (BHT) Services**
  - **Goal:** Establishing baseline
  - **Target Population:** Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age, as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.
  - **Description of Programs or Services:** Provide medically necessary BHT services to children with Autism Spectrum Disorder through early identification and early intervention in collaboration with the parents to promote optimal functional independence before aging out of the Regional Center system. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
  - **Activities:** Treatments include direct observation, measurement, and functional analysis of the relations between environment and behavior of children with ASD.

- **Practice Facilitation Team — Improve Practice Health & Safety Leveraging the QI Practice Facilitators Team**
  - **Goals**: Achieve and sustain 100% compliance in all Facility Site Review (FSR) audits year-over-year for primary care practices.
  - **Target Population:** Medi-Cal adults and children accessing primary care.
  - **Description of Programs or Services:** Enhancing the existing FSR nursing function by training nurses in QI facilitation skills to address any gaps from FSR audits to improve compliance with practice health and safety standards at the practice sites of the CalOptima Community Networks (CCN).
  - **Activities:** CalOptima will develop Practice Facilitator functions for the FSR nurses to identify opportunities to improve practice site health and safety, and provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices. CalOptima will coordinate with the community clinics, Federally Qualified Health Centers (FQHC), and eventually expand to other potential settings such as PACE to promote patient safety practices.

  - **Activities:** Collaborate with Health Networks' Transition of Care Home Visit Team, and/or community home health agencies to complete medication reconciliation during home visits post discharge.

- **Strategies to Manage Members with Multiple Chronic Illnesses [PHM1 A Factor 1,2]**

- **Whole-Child Model — Ensure Whole-Child-Centric Quality and Continuity Care for Children with CCS Eligible Conditions**
  - **Goal:** Improve Children and Adolescent Immunization HEDIS measures by 10% from the 2018 baseline by December 2020 (excluding children and adolescent under cancer treatment)
    - Improve Childhood Immunization Status Combo10 for Children with CCS eligible conditions to ≥37.0% (2018 Baseline = 33.3 %)
    - Improve Immunization for Adolescents with CCS eligible conditions to ≥ 50.0% (2018 Baseline = 45.33%)
  - **Targeted Population:** Children with CCS Eligible Conditions
  - **Description of Programs or Services:** The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results. Currently, children who have CCS-eligible diagnoses are enrolled in and get care from both the county CCS program for their CCS condition and CalOptima for their non-CCS conditions, routine care and preventive health. Beginning July 1, 2019, Orange County Medi-Cal CCS eligible children will receive services for both CCS and non-CCS conditions from CalOptima. Children whose CCS care will be transitioning under WCM to CalOptima on July 1, 2019, are referred to as Transitioning WCM members.
    Activities: CalOptima identifies children with potentially eligible CCS conditions. Upon confirmation of CCS Program eligibility, CalOptima assigns a Personal Care Coordinator (PCC) to each Member. The PCC assists the members and family to navigate the health care system, accessing high quality primary care providers, CCS-paneled specialists, care centers and Medical Therapy Units. The primary goal is facilitation of timely, appropriate health care and coordination among the health care team, especially including the member and family.

- **Health Home Program (HHP) — Improve clinical outcomes of members with multiple chronic conditions and experiencing homelessness**
  - **Goal:** Establishing baseline measures in 2018
    - Member Engagement Rate
    - Inpatient Readmissions
    - Emergency Department (ED) Visits
  - **Target Population:** DHCS identified list of *highest risk 3-5 % of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria:*
    - Specific combination of physical chronic conditions and/or substance use disorder (SUD) or specific serious mental illness (SMI) condition;

- Meet specified acuity/complex criteria
- Eligible members consent to participate and receive Health Home Program services.

- **Description of Programs or Services:** A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- **Activities:** Core services as defined by DHCS are detailed below.
    - Comprehensive care management
    - Health promotion
    - Care coordination
    - Individual and family support services
    - Comprehensive transitional care
    - Referral to community and social support services
    - Other new services
        - Accompany participants to critical appointments
        - Provider housing navigation services for members experiencing homelessness
        - Manage transition from non-hospital or nursing facility settings, such as residential treatment programs
        - Trauma informed care

❖ **PHM Activities and Resources [PHM 1A Factor 3]**

➢ CalOptima will use our annual population assessment to review and update our PHM structure, activities and resources. The annual population assessment helps CalOptima to set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity, and proactively mitigate emerging risk, such as partnering with Orange County Health Care Agency to address social determinants that adversely impacting the health and wellness of the CalOptima member population and relevant sub-populations. CalOptima actively seeks out community partners and leverages the Inter-Government Transfer (IGT) funds to support community collaborations.

➢ As the various health care sectors adopt technology to address the changing demographic of the population and bring needed care to members in non-traditional ways, CalOptima will be exploring the feasibility of advancing our mission to provide members with access to quality health care services leveraging advanced virtual technology. In order to bring timely care and services to a broader population, CalOptima will explore the feasibility of leveraging telehealth usage in cases ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in members' homes. CalOptima plan to seek the IGT funding to demonstrate the feasibilities of innovative telehealth approaches in Medi-Cal via pilot.

- **Expanding Strategies to Inform Members Leveraging Technology [PHM1 A5, PHM B]**
  - CalOptima deploys multiple methods for informing members about PHM programs and services. Based on the members' language preferences, members are informed of various health promotion programs, and how to contact Care Management, via the initial Member Packet in the mail, CalOptima website, personal telephone outreach or Robo calls, in person, and by email. One of the PHM strategies to support members age 19–40 is to develop telehealth technology enhanced methods of informing members, such as text or other mobile applications.
  - CalOptima PHM programs are accessible to eligible Orange County Medi-Cal beneficiaries who meet the PHM program criteria.
  - CalOptima provides instruction on how to use these services in multiple languages and at appropriate health literacy levels.
  - CalOptima honors member choice; hence, all the PHM programs are voluntary. The members can decline the program or opt out any time.

- **Delivery System for Practitioner/Provider Support [PHM3 A]**
  - **Information Sharing**
    - CalOptima Provider Relations and QI departments provide ongoing support to practitioners and providers in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids and continuing education sessions, and providing comparative quality and cost information. CalOptima will continue to improve information sharing with Health Network providers using integrated and actional data.
  - **Practice Transformation Technical Assistance (New Idea)**
    - One of the PHM strategies is to offer practice transformation support through Lean QI training, practice site facilitations and/or individualized technical assistance to improve member experience.
  - **Provider Coaching and Leadership Development (New Idea)**
    - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices and the top 30 providers with high volume grievances and potential quality of services issues.
    - Allocate one scholarship to sponsor community clinic physician leadership development through the California Health Care Foundation (CHCF) Health Care Leaders Fellowship.
  - **Pay for Value [PHM3 B]**
    - CalOptima already incentivizes providers based on quality performance in its directly contracted CalOptima Community Network (CCN) and the contracted Health Networks.

- **Population Health Management Impact [PMH 6]**

- **Measuring Effectiveness**
  - CalOptima annually conducts a comprehensive analysis of the PHM strategy's impact and effectiveness as part of the annual QI Program evaluation. The comprehensive analysis includes quantitative results for relevant clinical, cost, utilization, and qualitative member experience. CalOptima regularly compares its performance results with external benchmarks and internal goals. The results are reviewed and interpreted by the interdisciplinary through various QI Committees. Given the capability of Tableau, an enterprise analytic platform, CalOptima has the capability to conduct longitudinal QI Program Evaluation to ensure sustained effectiveness year over year.
- **Improvement and Action**
  - Based on the annual PHM program evaluation using internal and external data, CalOptima annually updates its QI Work Plan to improve CalOptima's PHM program and act on at least one opportunity for improvement within each of the quality domains (e.g., Member Experience, Effectiveness of Care, Provider Satisfaction, and Clinical Affordability) to achieve the Quadruple Aim.

***APPENDICES**:*

2018 NCQA PHM Standards

2019 Quality Improvement Program and QI Work Plan

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Betsy Chang Ha, RN, MS, LSS MBB
Executive Director, Quality & Population Health Management

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2019 QI Program Description Revisions

- Simplified description of Scope of Services for each line of business
- Updated the new program initiatives
  - Whole-Person Care (WPC)
  - Whole-Child Model (WCM)
  - Health Homes Program (HHP)
  - Population Health Management (PHM)
- Updated QI Program purpose to include Population Health accountability, annual review and acceptance process
- Update Authority, Board of Directors' — Quadruple Aim

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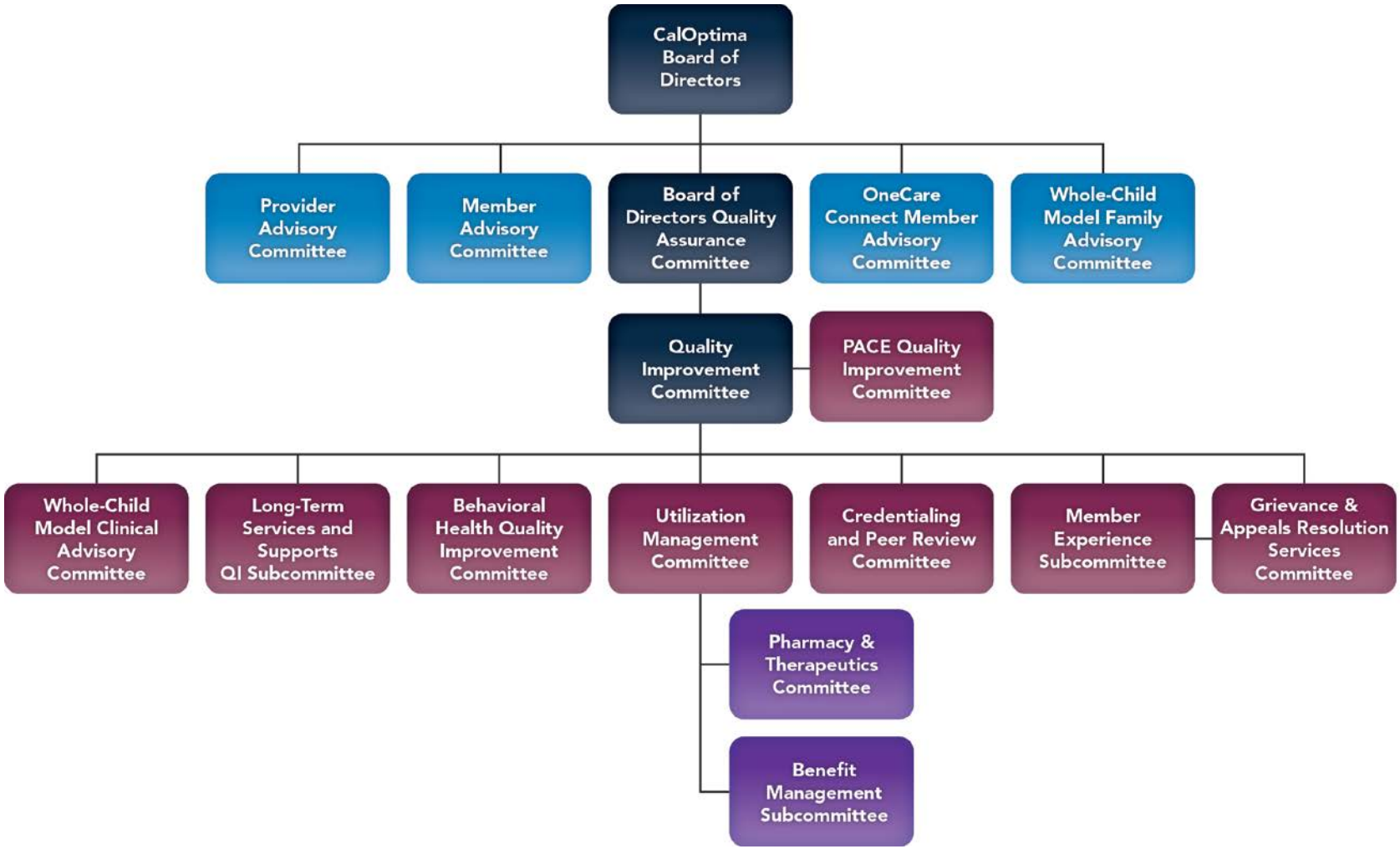
2019 QI Program Description Revisions (cont.)



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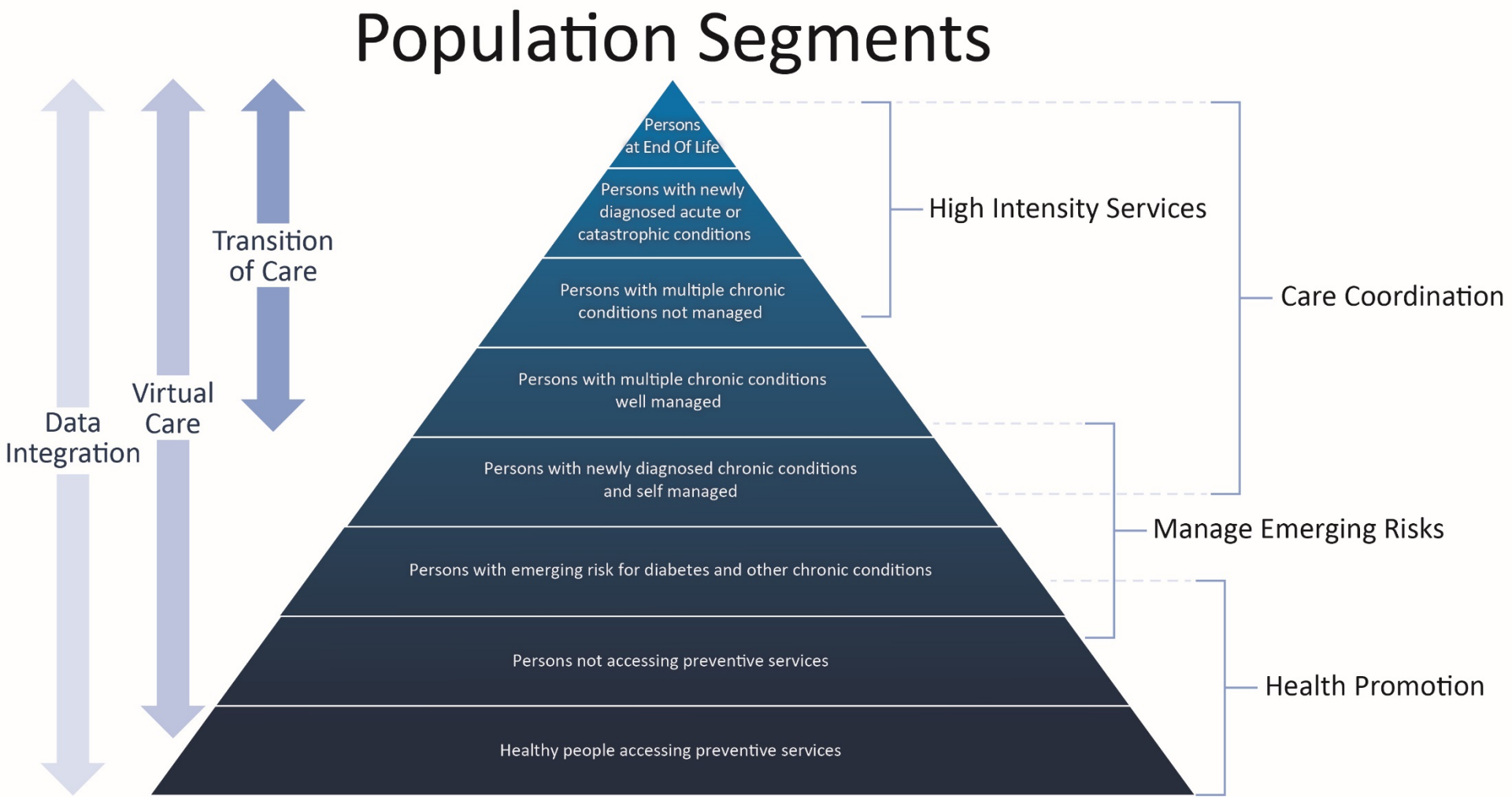
2019 QI Program Description Revisions (cont.)



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2019 QI Program Description Revisions (cont.)

- Established 2019 QI Goals and Objectives
  - Goal 1: Improve NCQA rating as the #1 Medi-Cal Health Plan in California, moving from 4.0 to 4.5 rating by 2021
  - Goal 2: Improve CalOptima Community Network (CCN) performance ranking to #3 among all health networks
  - Goal 3: Improve Member Experience from 25th percentile to exceed 50th percentile by 2020
- Developed 2019 QI Work Plan (Appendix A)

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2019 QI Program Description Revisions (cont.)

- Other revisions
  - Methodology — Introduced lead and lag measures
  - Communication of QI Activities to include Quality Forum
  - Staff responsibility and positions updated
  - QI Lean Training Curriculum added to CalOptima University in 2019
  - Include de-Credentialing to Corrective Action Plans
  - Added new sections: PHM, Long-Term Services and Supports, and Behavioral Health Integration
  - Added Group Needs Assessment and PHM to Safety section
  - Added Chinese and Arabic to C&L services

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2019 QI Program Description Revisions (cont.)

- Updated Delegated and Non-Delegated Activities (Appendix B)
  - Changed pre-delegation review to Readiness Assessment
  - PHM program renamed from Disease Management or Chronic Care Improvement Program
  - Renumbered based on 2018 Standards

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2019 QI Work Plan (Appendix A)

- QI Work Plan measures aligned with 2019 QI Goals and Objectives
- Utilize SMART goals incorporating both lag and lead measures in Work Plan
- Clinical Measures organized by populations:
  - Adult Health — Mental
  - Adult Health — Physical
  - Child/Adolescent Health
  - Chronic Conditions
  - Maternal Child Health

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2019 QI Work Plan (Appendix A) (cont.)

- Carried over measures that did not meet goals in 2018, and includes measures requiring extra focus and attention
- Includes measures for Safety of Clinical Care, Quality of Service and Member Experience
- Removed maintenance of business goals on the Work Plan, measures tracked in other areas, and measures that are performing well
- Reduced from 124 in 2018 to less than 40 in 2019

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2018 Utilization Management Program Evaluation

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Tracy Hitzeman, RN, CCM
Executive Director, Clinical Operations

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2018 UM Program Evaluation

- Annual evaluation approved by UMC, QIC and QAC
  - Analyzes plan performance against 2018-approved goals in two general areas:
    - Operational Performance
    - Outcomes
  - Includes status of focused initiatives described in the 2018 UM Program Description
  - Informs areas of opportunity to address in 2019 UM Program

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2018 UM Program Evaluation

- Operational Performance:
  - Authorization processing timeliness met the 2018 goals for routine requests
  - Expedited requests did not meet the goals (-1% variance)
- Utilization Outcomes:
  - Inpatient utilization (Bed Days/Per Thousand Members Per Year [PTMPY]) met goals with the exception of the first quarter
  - Readmissions rate stable
  - ED visit/PTMPY did not meet goals, especially in the TANF population
  - Retail Pharmacy $PMPM below goal - All LOB

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2018 UM Program Evaluation

- Accomplishments:
  - Opioid analgesic utilization decreased 8.5% (Q3 2017 ⇨ Q3 2018)
  - Provider data enhancement project underway with Process Excellence team
  - Addition of UM Data Analyst to support robust program monitoring
  - In-depth review of California Children's Services program and numbered letters in preparation for WCM transition
- Opportunities for 2019:
  - Improve timeliness of expedited request processing
  - Continued focus on transitions across settings

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2018 CalOptima Utilization Management Program Evaluation
January 7, 2019

Executive Summary

The 2018 Utilization Management (UM) Program and Work Plan describe 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.

I Projects, Programs and Initiatives:

A. Utilization Management

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

- Upgrades/enhancements to the Guiding (GC) Care Utilization Review Module in CalOptima's medical management system
- 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

The Medical Director of UM provides clinical oversight for the administration of the UM Program. He supports the UM process by both ensuring that treatment requests are processed using regulatory sources and clinical evidence-based criteria, and by evaluating the program's effectiveness against established goals. For areas not meeting goals, program changes are proposed and approved by the UM Workgroup and UMC and implemented by the UM Leadership staff. The UM Medical Director supports provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee, (BMSC) to evaluate new and changing benefits and determine the need for prior authorization and the bi-weekly UM Work Group, who provide 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. He also provides support and education to the UM department staff through twice weekly concurrent review case rounds and review and decision for adverse determinations.

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During 2018, the UM Medical Director held quarterly round table meetings with the Prior Authorization team, discussing emerging treatment protocols and providing a forum for staff to identify and share best practices. During twice-weekly concurrent review case rounds, the UM Medical Director led discussions with the nursing and physician group on current cases, including both clinical and practical aspects of managing the cases and assisting with discharge planning. Topics discussed in 2018 included genetic testing, transgender procedures, management of administrative days, appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria, Letter of Agreement (LOA) process, and one-day inpatient stays.

In 2018, 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

Effective January 1, 2018, CalOptima began to directly manage all the administrative functions of the Medi-Cal mild to moderate mental health benefits and behavioral health treatment (BHT) services 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 remains as CalOptima's Managed Behavioral Health Organization (MBHO) with full spectrum of administrative responsibilities including UM, provider network, credentialing, customer service, inpatient services, and care coordination. BHI continued to partner with Health Network (HN) management to provide oversight of the MBHO's delivery of the mental health services and administrative functions.

The Behavioral Health Quality Improvement (BHQI) Subcommittee continued to be held on a quarterly basis and reported to the QIC. The BHQI trends, analyzes and identifies improvement areas for behavioral health (BH) services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers The BHQI is chaired by the BH Medical Director and comprised of internal and external subcommittee members, including delegated 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 2018 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 2018, 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

Continued refinement was applied to data standards for tracking and trending of metrics for both CalOptima and the delegated health networks. Decreased data lag was accomplished by implementation of a new (XML) file format for health network submission of authorization 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.

UM report design and generation is supported by CalOptima's Enterprise Analytics (EA) and Information Services (IS) department staff.

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

Medi-Cal

In 2018, oversight of the delegated HNs for UM was performed by CalOptima's A&O Committee. Monthly, each of the delegates was monitored for the following activities:

- 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 performed well for timeliness of decision and notification 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

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, the HN files ranged between 67–100% compliance with the standard, representing an opportunity for continued focus in this area.

Notifications

The delegated HNs are audited regularly on member notifications (NOAs). In 2018, compliance to standard ranged from 74–100%; this continues to be a focus for improvement.

2018 CalOptima Utilization Management Program Evaluation

OCC

In 2018, oversight of the delegated HNs for UM was performed by CalOptima's A&O Committee. On a quarterly basis, each of the delegates were monitored for the following activities:

- 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 performed at **98%** compliance rate for timeliness of decision and notification for routine pre-service authorizations. For expedited requests, the HNs, 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 2018, the HN files ranged between 85–100% compliance with the standard representing an opportunity for continued focus in this area.

Notifications

The delegated HNs are audited regularly on member notifications (NODs). In 2018, compliance to standard ranged from **53–100%**; this continues to be a focus for improvement.

OC

In 2018, oversight of the delegated HNs for UM was performed by CalOptima's A&O Committee. On a monthly basis, each of the delegates were monitored for the following activities:

- 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 performed at 85–100% 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.

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 2018 scores ranged from **72% (one outlier) to 100%**.

Notifications The delegated HNs are audited regularly on member notifications (NODs). In 2018, compliance to standard ranged from 95–100%, representing significant improvement over 2017.

Inpatient and Emergency Department (ED) Utilization Performance

Medi-Cal (MC) Shared Risk Average Length of Stay (ALOS): Trended downward in Q1-3 2018 for Seniors and Persons with Disabilities (SPD) and Temporary Assistance for Needy Families (TANF) > 18 and remained stable and at 3.0 or below for TANF ≤ 18

- **Bed Days/Per Thousand Members Per Year (PTMPY):** 2018 goal was consistently met for all subpopulations (SPD, TANF ≤18, TANF >18 and) except for Q1 TANF ≤18 which exceeded goal by 17%.
- **Readmissions:** Stable Trend Q1-3; SPD average 23%, TANF > 18 average 15.6%, TANF < 18 average 2.9%
- **ED Visits/PTMPY:**
  - **SPD:** goal was met in Q1 and Q2, goal exceeded by 10% in Q3
  - **TANF ≤ 18:** goal was not met in 2018 but trended down from Q1-3
  - **TANF > 18:** goal was not met in Q1 and Q3

Shared Risk - MC	Goal	Q1	Q2	Q3
SPD				
ALOS	-	4.9	4.4	3.9
Bed Days/PTMPY	1120	1,112	942	949
Readmissions	-	22%	24%	23%
ED Visits/PTMPY	700	694	689	776
TANF >18				
ALOS	-	4.4	4.3	3.8
Bed Days/PMPY	360	294	299	314
Readmissions	-	17%	16%	14%
ED Visits/PTMPY	430	441	428	479
TANF ≤18				
ALOS	-	2.9	2.8	3.0
Bed Days/PTMPY	40	48	34	40
Readmissions	-	2%	4%	1%
ED Visits/PTMPY	310	426	313	331

Medi-Cal CCN

- **Average Length of Stay**
  - **SPD:** Stable trend with slight spike to 5.3 in Q2
  - **TANF > 18:** Stable trend with average at 4.3 days
  - **TANF ≤ 18:** goal was not met in 2018 but trended down in Q1-3
- **Bed Days/PTMPY:** 2018 Bed Days goals were met for each of the subpopulations
- **Readmissions:** Stable Trend Q1-3; SPD average 24%, TANF > 18 average 21%, TANF < 18 average 2%
- **ED Visits/PTMPY**
  - **SPD:** goal was not met in 2018
  - **TANF > 18:** goal was not met in 2018
  - **TANF ≤ 18:** goal was met in Q1 2018; not met in Q2 and Q3

CCN	Goals	Q1	Q2	Q3
SPD				
ALOS	-	4.4	5.3	4.6
Bed Days/PTMPY	1830	1,679	1,763	1,784
Readmissions	-	25%	25%	23%
ED Visits/PTMPY	640	932	891	1,027
TANF >18				
ALOS	-	4.5	4.3	4.0
Bed Days/PMPY	710	465	472	458
Readmissions	-	22%	22%	18%
ED Visits/PTMPY	490	622	623	685
TANF≤18				
ALOS	-	4.0	2.2	2.2
Bed Days/PTMPY	100	65	28	32
Readmissions	-	6%	0%	0%
ED Visits/PTMPY	470	545	419	429

2018 CalOptima Utilization Management Program Evaluation

The CalOptima Direct Administrative 2018 Bed Day and ED visit goals for the year were met, except for the first quarter for TANF members ≤18 for Bed Days and ED visits were slightly above goal in Q1.

COD	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.3	5.4	4.9
Bed Days/PTMPY	1920	926	856	657
Readmissions	-	3%	3%	2%
ED Visits/PTMPY	1120	74	76	75
TANF >18				
ALOS	-	4.7	5.1	4.2
Bed Days/PMPY	600	362	447	374
Readmissions	-	17%	16%	10%
ED Visits/PTMPY	580	384	429	449
TANF≤18				
ALOS	-	3.0	3.7	3.2
Bed Days/PTMPY	75	84	49	45
Readmissions	-	3%	0%	0%
ED Visits/PTMPY	400	418	314	295

2018 CalOptima Utilization Management Program Evaluation

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

Shared Risk - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	-	4.5	5.0	4.5
Bed Days/PTMPY	1340	852	1,065	912
Readmissions	-	19%	20%	17%
ED Visits/PTMPY	410	385	422	432
TANF>18				
ALOS	-	3.8	4.9	4.5
Bed Days/PTMPY	-	594	1,012	873
Readmissions	-	5%	11%	10%
ED Visits/PTMPY	-	509	481	493

2018 CalOptima Utilization Management Program Evaluation

OCC CCN demonstrated improvement in bed day utilization in 2018, though ED usage was higher than anticipated. 2018 OCC CCN Data will be reviewed in 2019, and additional interventions may be applied as needed.

CCN - OCC	Goals	Q1	Q2	Q3
SPD				
ALOS	-	5.2	4.4	5.3
Bed Days/PTMPY	1980	1,573	1,138	1,064
Readmissions	-	14%	22%	11%
ED Visits/PTMPY	410	609	600	680
TANF>18				
ALOS	-	3.8	6.1	3.7
Bed Days/PTMPY	-	1,437	1,919	975
Readmissions	-	24%	18%	19%
ED Visits/PTMPY	-	594	697	1,082

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	-	6.3	5.1	4.1
Bed Days/PTMPY	1370	1,238	857	642
Readmissions	-	20%	12%	4%
ED Visits/PTMPY	480	420	419	439

Over and Underutilization is monitored, tracked, managed and reported by Quality Analytics, Quality Improvement, UM and Case Management and reported to QIC, UMC, and QAC by product at least quarterly in 2018. 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.

III Operational Performance

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

2018 - Summary of referral volume (Quarter 1Quarter 3)

Referrals Processed		Referrals Received		Turnaround Time Compliancy (TAT)	
Routine:	**150,494**	Faxed:	**78,074**	Routine TAT:	**99.9%**
Urgent:	**16,805**	COLAS:	**97,240**	Urgent TAT:	**99.1%**
Retro:	**7,643**	Total:	**175,314**	Retro TAT:	**99.5%**
Total:	**174,942***				

Total volume of referrals increased from 2017 by 48,335 or 38.2%
Volume of faxed referrals increased from 2017 by 28,947 or 58.9%
Volume of portal (COLA) referrals increased from 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 the 3 quarters was 55% in 2018 and was 63% over 4 quarters of 2017.

Referral TAT was compliant for all referral types in the first 3 quarters of 2018.

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

Annual summary of turnaround time compliance, 2018:

OC: 100%
OCC: 99.7%
Medi-Cal: 98.8%

Pharmacy Prior Authorization TAT processing time are above goal of 97% for OC and OCC. 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 2018.

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 2018:
  - CBAS CEDT: 100%
  - CBAS Routine: 99%
  - CBAS Expedited: None received
  - LTC Routine: 100%
  - LTC Urgent: None received

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 2018. 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: 95%

E. Denial (Letter) Process

Performance has continued to improve throughout 2018. 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 2018 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 2018 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 2018 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.

Review of 2018 ED Data will be conducted, and additional interventions may be applied as needed.

B. Pharmacy Utilization

- 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 2018, 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 2018

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals related to the UM Program. In 2018, complaints about the UM Program demonstrated some trends in the following categories:

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

  - 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 2018

- 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 2018, CalOptima made progress improving the effectiveness of the UM program and decreasing administrative barriers. 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. The UMC held a virtual meeting in January and met four additional times in 2018 on March 22, May 24, August 23 and November 29. Pharmacy and Therapeutics Committee (P&T) and the BMSC reported quarterly to the UMC in 2018. Quarterly UM operational performance and health care utilization data analysis and trends are presented, reviewed and discussed at the UMC and guide future efforts of the CalOptima UM Program.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 20, 2019
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

5. Consider Recommending Board of Directors' Approval of the 2019 CalOptima Utilization Management (UM) Program

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations, (714) 246-8400

Recommended Action

Recommend Board of Directors' approval of the 2019 Utilization Management (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 2019 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 2019 Utilization Management Program is based on the Board-approved 2018 Utilization Management Program and describes: (i) the scope of the program; (ii) the progam structure and services provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and (vi) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.

The revisions are summarized as follows:

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1. Aligned program descriptions and committee references with the Quality Management Program and approved committee charter updates.
2. Updated program to reflect the transition of California Children's Services program to the Whole Child Model program effective July 1, 2019.
3. Included a description of the Health Homes program and CalOptima's implementation plan.
4. Included a description of CalOptima's Population Health Management strategy for 2019.
5. Updated description of responsibilities for various key positions.
6. Modified reference to CalOptima's health networks to reflect changes in participating networks since 2018.

The recommended changes are designed to better review, analyze, implement and evaluate the components of the UM Program, 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. Proposed 2019 Utilization Management Program
2. PowerPoint Presentation – 2019 Utilization Management Program Description

/s/ Michael Schrader — *2/14/2019*
Authorized Signature — **Date**

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2019~~8~~ UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

20189 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Francesco Federico, 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, MD **Date**

Table of Contents

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima 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 ~~our~~ members.

Our Values — CalOptima CARES

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

Accountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, 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.

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
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.
-

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is ~~unique~~ unusual in that **IT IS** both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optional 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 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% ~~percent~~ between 2014 and 2016!

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

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

~~Acupuncture~~	~~Hospice care~~	~~Outpatient mental health services – limited~~
~~Adult preventive services~~	~~Hospital/inpatient care~~	~~Pediatric preventive services~~
~~Community based adult services~~	~~Immunizations~~	~~Child health and disability prevention (CHDP)~~
~~Doctor visits~~	~~Laboratory services~~	~~Physical therapy~~
~~Durable medical equipment~~	~~Limited allied health services~~	~~Prenatal care~~
~~Emergency care~~	~~Medical supplies~~	~~Specialty care services~~
~~Emergency transportation~~	~~Medications~~	~~Speech therapy~~
~~Non-emergency medical transportation (NEMT) and non-medical transportation (NMT)~~	~~Newborn care~~	~~Substance use disorder preventive services – limited~~
~~Hearing aid(s)~~	~~Nursing facility services~~	~~Vision care~~
~~Home health care~~	~~Occupational therapy~~	

Certain services are not covered by CalOptima, ~~or~~ 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.

- Eligible conditions under California Children's Services (CCS) ~~will be covered by the CCS program through June 30, 2019. Beginning~~Effective July 1, 2019 or such later date as the program becomes effective, this program ~~eligible conditions under California Children's Services (CCS)~~ will be ~~covered~~managed by CalOptima ~~under~~through the Whole--Child Model (WCM) 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 Case Management (CM) Programthe 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 through as special programs, such as the services through CalOptima's Mmember Lliaisons program, and through specific Memoranda of Understanding (MOU) with certain community agencies, including OC HCA, CCS (through June 30, 2019, or such later date as the Whole Child Model becomes affective) and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

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

These integrated LTSS benefits include three programs:

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

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who 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.be enrolled in Medi-Cal and Medicare Parts A and B, and not be eligible for OCC.

Scope of Services

In addition to the comprehensive scope of acute and preventive care services covered under Medi-Cal and Medi-Care benefits, CalOptima OC members are eligible for enhanced services such as

transportation to medical services and gym membership.~~OC provides a comprehensive scope of services for the dual eligible members who are not eligible for OCC, and who voluntarily enroll in OC.~~

~~These services include but are not limited to the following:~~

~~Acupuncture and other alternative therapies~~	~~Gym membership~~	~~Prescription drugs~~
~~Ambulance~~	~~Hearing services~~	~~Preventative care~~
~~Chiropractic care~~	~~Home health care~~	~~Prosthetic devices~~
~~Dental services – limited~~	~~Hospice~~	~~Renal dialysis~~
~~Diabetes supplies and services~~	~~Inpatient hospital care~~	~~Skilled nursing facility~~
~~Diagnostic tests, lab and radiology services, and X-rays~~	~~Inpatient mental health care~~	~~Transportation for medical and pharmacy visits~~
~~Doctor visits~~	~~Mental health care~~	~~Urgently needed services~~
~~Durable medical equipment~~	~~Outpatient rehabilitation~~	~~Vision services~~
~~Emergency care~~	~~Outpatient substance abuse~~	
~~Foot care~~	~~Outpatient surgery~~	

OneCare Connect

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

These members often 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 enhanced dental benefits~~ and an out of the country urgent/emergency care benefit.~~.~~ Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results is 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 services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care and gym benefits. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

~~Acupuncture (pregnant women)~~	~~Hearing aids – limited~~	~~Rehabilitation services~~
~~Ambulance services~~	~~Hearing screenings~~	~~Renal dialysis~~
~~Case management~~	~~Incontinence supplies – limited~~	~~Screening tests~~
~~Chiropractic services~~	~~Inpatient hospital care~~	~~Skilled nursing care~~
~~Community-based adult services (CBAS)~~	~~Inpatient mental health care~~	~~Specialist care~~
~~Diabetes supplies and services~~	~~Institutional care~~	~~Substance abuse services~~
~~Disease self-management~~	~~Lab tests~~	~~Supplemental dental services~~
~~Doctor visits~~	~~Medical equipment for home care~~	~~Transportation for medical and pharmacy visits~~
~~Durable medical equipment~~	~~Mental or behavioral health services~~	~~Transgender services~~
~~Emergency care~~	~~Multipurpose Senior Services Program (MSSP)~~	~~Occupational, physical or speech therapy~~
~~Eye exams~~	~~Over-the-counter drugs – limited Prescription drugs~~	~~Urgent care~~
~~Foot care~~	~~Outpatient care~~	~~"Welcome to Medicare" preventive visit~~
~~Glasses or contacts – limited~~	~~Preventive care~~	
~~Gym membership~~	~~Prosthetic devices~~	
~~Health education~~	~~Radiology~~	

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 ~~our~~ Orange County ~~service area~~, be determined ~~as~~ 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 is a managed care service delivery model that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE program provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support coordinated from a central location. CalOptima currently serves approximately 300 members via the CalOptima PACE center and four (4) operating alternative care settings. Financing for the program is capped, which allows providers to deliver all services participants need rather than limit them to those reimbursable under Medicare and Medicaid fee-for-service plans.~~

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, dieticians, 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 participates.

~~PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for participants, based on their needs as indicated by the Interdisciplinary Team.~~

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.

NEW PROGRAM INITIATIVES ~~ON OUR HORIZON~~

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 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 Connect information sharing platform was launched in November 2018. For 2019 the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole--Child Model ~~(WCM)~~

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.

Through SB 586, the State has required CCS services to become a Medi-Cal managed care plan benefit in select counties. The goal is 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 the Whole-Child Model (WCM). Under this model, in Orange County, eligibility determination processes and the Medical Therapy Program 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. ~~No sooner than July 1, 2019, CalOptima shall assume responsibility for CCS for CalOptima Members who are eligible for the California Children's Services (CCS) Program, and transitioned into the Whole Child Model (WCM) program, newly CCS-eligible Members, or new CCS Members enrolling in CalOptima, including the identification and referral of Members with CCS-Eligible Conditions. CalOptima and CalOptima's delegated Health Network shall assume responsibility for authorization and payment of CCS-eligible medical services, which include authorization activities, claims processing and payment, case management, and quality oversight and coordination of all Medi-Cal and CCS-covered services, as well as Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), for enrolled Members.~~

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 plans to implement HHP in the following two phases: July 1, 2019 for members with chronic physical conditions or substance use disorders (SUD), and January 1, 2020 for members with serious mental illness or Serious Emotional Disturbance (SMI).

DHCS is targeting the highest-risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. DHCS will 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 home providers. In addition to CalOptima's Community Network, some HNs 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
   - Referral to community and social support services~~No sooner that July 1, 2019, CalOptima shall implement the Health Homes Program (HHP) for members with eligible chronic conditions or substance use disorders. The program is designed to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries and will provide six core services:~~
   - ~~Comprehensive care management~~
   - ~~Care coordination (physical health, behavioral health, community based LTSS)~~
   - ~~Health promotion~~
   - ~~Comprehensive transitional care~~
   - ~~Individual and family support~~
   - ~~Referral to community and social support services, including housing~~
6.

Population Health Management (PHM)

CalOptima has developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy includ~~ing~~es a plan of action for addressing our culturally diverse member 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 the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

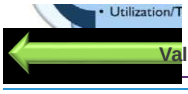
The 2019 PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March

2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.

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

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 ~~as illustrated below in Figure 1. The PHM Conceptual Model is adapted from the model created by the Association of Community Affiliated Plans~~. CalOptima added the PHM Value Based Payment Arrangement as the foundation to align the future Pay for Value program methodology.

~~See Appendix A — 2019 PHM Strategy~~



~~**Whole Person Care**~~

~~Whole Person Care is a five-year pilot established by DHCS as part of California's Medi-Cal 2020 strategic plan and led by the Orange County Health Care Agency. It will focus on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness.~~

CALOPTIMA'S PROVIDER NETWORKS:

~~WHOM WE WORK WITH:~~

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima ~~health network~~HN, and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose one of ~~15~~ 143 ~~health networks (~~HNs~~)~~, representing more than ~~7,500~~8,3~~4~~00 practitioners.

Health Networks

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 6,7~~8~~00 specialists, 23 hospitals, 23 clinics and 100 long-term care facilities.

~~**CalOptima Community Network (CCN)**~~

~~The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 14~~ 12 ~~HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th~~ 13th ~~network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.~~

CalOptima Direct (COD)

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

CalOptima Direct-Administrative (COD-A)

CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's ~~MA-D SNP~~OneCare Connect or OneCare programs), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct are not ~~health network~~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. Currently, CalOptima contracts with 13 HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.

~~**Health Networks**~~

~~CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to more than 1,594~~3 ~~Primary Care Providers (PCPs), nearly 6,092~~ 731 ~~specialists, 30~~ 23 ~~hospitals, and 36~~ 23 ~~community health centers,~~ clinics. ~~and 100 long-term care facilities. New health networks that demonstrate the ability to comply with CalOptima's delegated~~

~~requirements are added as needed with CalOptima Board approval.~~

The following are CalOptima's contracted health networks:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western ~~Health Network~~Medical Group	SRG	SRG	SRG
~~CCN~~			
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage ~~Provider Network Regal~~	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
~~OC Advantage Medical Group~~	~~PHC~~		~~PHC~~
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
A Public Agency
Better. Together.

Fast Facts: January 2019

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, 2018

Total CalOptima Membership
769,216

Program	Members
Medi-Cal	752,888
OneCare Connect	14,610
OneCare (HMO SNP)	1,423
Program of All-Inclusive Care for the Elderly (PACE)	295

Note: The Fiscal Year 2018-19 Membership Data started on July 1, 2018.

Member Age (All Programs)

11%	0 to 5
30%	6 to 18
29%	19 to 44
18%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
28%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

43%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define CalOptima's structure and processes to review 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 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, National Committee for Quality Assurance (NCQA) Standards and evidence 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.
- Identify and refer high-risk members to Care CoordinationCase Management Programs, including Complex Case Management, Long-Term Services and Supports (LTSS), Behavioral Health and/or Health Education & Disease Population Health Management Programsservices 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.
- Promotes improved member health and well-being by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), County Specialty Mental Health and California Children's Services (CCS).

- Educate practitioners and other providers, including delegated ~~Health Networks~~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.

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 p~~P~~olicies and p~~P~~rocedures, ~~;~~ including timeframes outlined in CalOptima's ~~policy~~ 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 ~~Monthly~~ reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, Utilization ~~M Committee~~Management Committee (UMC) and/or Quality Improvement Committee (QIC).
- Regular audits of delegated HNs utilization management activities by the Audit and Oversight ~~D~~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 ~~state~~ 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~~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
    - Nursing Facility Level A
    - Subacute Adult and Pediatric
    - Intermediate Care Facility ~~/~~ Developmentally Disabled, (ICF/DD)
    - Intermediate Care Facility ~~/~~ Developmentally ~~Disabled~~ Disabled Habilitative, (ICF/DD-H)
    - Intermediate Care Facility ~~/~~ Developmentally ~~Disabled~~ Disabled Nursing, (ICF/DD-N)
- Medical necessity for LTC is evaluated based upon the ~~Department of Health Care Services (~~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:

- ~~Community Based Adult 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).
- ~~Multipurpose Senior Services Program (~~MSSP~~)~~: Home and ~~community based~~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 ~~Outpatient Behavioral Health Services~~

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services ~~include, but~~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 directly manages all administrative functions of the Medi-Cal mental health benefits~~

~~including utilization management, claims, credentialing the provider network, member services, and quality improvement.~~

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting ~~Behavioral health services within the scope of practice for primary care physicians (PCPs) include screening, brief intervention, and referral to treatment (SBIRT) services~~ 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. ~~In addition, PCPs frequently manage the treatment of their patients' mental health conditions.~~

~~If a member needs behavioral health services not provided by their PCP,~~ CalOptima members can access mental~~behavioral~~ 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. ~~representative for behavioral health assistance. The member will be provided with several behavioral health practitioners contact information, based upon geographic proximity to the member's residence and their clinical needs. If the member meets criteria for Specialty Mental Health Services, the member is referred to the Orange County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima~~

~~In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).~~

CalOptima ensures members with coexisting medical and mental~~behavioral~~ health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental~~behavioral~~ 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~~behavioral~~ health practitioners involved.

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

~~OneCare~~ OC and O~~ne~~Care ~~Connect~~CC ~~Behavioral Health Services~~

CalOptima has contracted with Magellan Health Inc. to directly manage the mental health benefits for ~~for the behavioral health services portion of~~ O~~ne~~Care and O~~ne~~Care ~~Connect~~ members. Functions delegated to Magellan include provider network, ~~utilization management~~UM, credentialing, and customer service.

CalOptima O~~ne~~Care and O~~ne~~Care ~~Connect~~ members can access mental~~behavioral~~ health services by calling the CalOptima Behavioral Health Line ~~at 855-877-3885~~. By selecting the O~~ne~~Care or O~~ne~~Care ~~Connect~~ 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. ~~behavioral health triage. If office based services are appropriate, the member is registered and given referrals to an appropriate provider. If ambulatory Specialty Mental Health needs are identified, services may be rendered through the Orange County Mental Health Plan.~~

CalOptima offers Alcohol Misuse Screening and Counseling (AMSAC) services ~~at~~in the ~~primary care physician~~~~pcp~~PCP setting~~screening, brief intervention, and referral to treatment (SBIRT) services~~ 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 ~~ensure that~~ members with special health care needs, or high risk or complex medical and developmental conditions~~, receive wrap around services that enhance their medical benefits~~. These linkages are established through special programs, such as the CalOptima Community Liaisons, ~~Personal Care Coordinators (~~PCCs~~).~~ Behavioral Health Integration (BHI), Long~~-~~-Term Services and Supports (LTSS) and specific program ~~Contracts~~ contracts and ~~Memoranda of Understanding (~~MOUs~~)~~ with other community agencies and programs, such as the ~~Orange County Heath Care Agency'~~OC HCA's ~~California Children's Services~~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 ~~and/or Disease Management~~ department~~s~~ 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.

~~CalOptima's Utilization Management Program~~Authority, Boards of Directors' Committees, and Responsibilities

~~CalOptima~~ Board of Directors

~~Authority, Responsibility and Accountability~~

The CalOptima Board of Directors has ultimate ~~authority,~~ 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 ~~Chief Executive Officer (~~CEO~~)~~ and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. CalOptima promotes ~~The Board of Directors~~ 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 ~~Utilization Management Committee (~~UMC~~)~~, the ~~Quality Improvement Committee (~~QIC~~)~~ and the ~~Quality Assurance Committee (~~QAC~~)~~ on an annual basis.

Role of CalOptima Officers for Quality Improvement Program

~~CalOptima Officers and Directors~~

CalOptima's ~~Chief Medical Officer~~CMO, ~~Deputy CMO,~~ Chairperson of the ~~Utilization Management Committee~~UMC, ~~and~~ 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 ~~quality improvement~~QI, medical and behavioral health utilization review and authorization, case management, ~~disease management~~population health ~~management~~PHM and health education program implementations. ~~, with successful operation of the UMC, QIC and QAC.~~

Chief Medical Officer

The ~~Chief Medical Officer (~~CMO~~), along with the Deputy Chief Medical Office (DCMO)~~ — or physician designee — oversees CalOptima's ~~the~~ UM Program, including the strategies, programs, policies and procedures related to CalOptima's medical care delivery system. ~~The CMO and DCMO oversee CalOptima's UM Program.~~

~~**Deputy Chief Medical Officer**~~

~~The Deputy Chief Medical Officer (DCMO). along with the Chief Medical Office (CMO) oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system.~~

~~**Deputy Chief Medical Officer**~~

~~The Deputy Chief Medical Officer (DCMO). along with the Chief Medical Office (CMO) oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system.~~

Executive Director, ~~of~~ Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the ~~Utilization Management~~UM, Case Management, and Managed Long-Term Services and Support (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of C~~linical~~ O~~perations~~ serves as a member of the executive team, and, with the CMO ~~, DCMO~~ and the ~~ED of~~Executive Director, Quality & Analytics (ED of Q&A) ~~ensures~~ 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~~linical~~ O~~perations~~ is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources.

Medical Director, ~~of~~ Utilization Management, appointed by the CMO ~~and/or DCMO~~, is responsible for the direction of the UM Program objectives 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 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~~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, the Medical Director of UM also provides supervisory oversight and administration of the UM Program. In this role, the Medical Director oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process ~~The Medical Director of UM also oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions.~~ Medical Director of UM provides clinical education and in-services to staff ~~weekly and on an as needed basis~~, 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. He or she serves as the Chair of the ~~Utilization Management Committee~~UMC and the Benefit Management Subcommittee, facilitates the bi-weekly UM Workgroup meetings , and participates in the CalOptima Medical Directors Forum and ~~Quality Improvement Committee~~QIC.

~~**Utilization Management 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. In this role, the Medical Director oversees the UM activities 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. Ensures availability to staff during normal business hours and on-call after hours.~~

Medical Director, Behavioral Health 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 care services for CalOptima members. The Medical Director provides clinical oversight for behavioral health 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 behavioral health outcomes. The Behavioral Health Medical Director is involved in the implementation, monitoring 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 and OneCare Connect), Managed LTSS (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 ~~Disease Management~~Population Health Management, Grievance and Appeals, and Provider Relations. The Medical Director works closely with the nursing and non-clinical leadership of these departments.

Medical Director ~~Disease Management~~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 disease management and health education programs, while also providing clinical quality oversight of the PACE Program.

Director, ~~of~~ Utilization Management is responsible for directing and coordinating the planning, organization, implementation and evaluation of all activities and personnel engaged in UM d~~D~~epartmental activities. The ~~D~~director develops and implements the UM Program and UM Work Plan, maintains and updates policies, procedures and work flows to meet regulatory, contractual and accreditation standards.

Director, ~~of~~ Behavioral Health Services provides operational oversight for behavioral health benefits and services provided to members. The ~~D~~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 health 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, ~~health network~~HN management, legal counsel, state and federal officials, and representatives of other agencies.

~~**Director of Quality Director of Quality** is responsible for ensuring that CalOptima and its HMOs PHCs and SRGs meet the requirements set forth by DHCS and Centers for Medicare/Medicaid Services (CMS. The Compliance staff works in collaboration with the CalOptima Quality Improvement department to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas, such as UM, Credentialing, and Grievance & Appeals Resolution Services (GARS), as appropriate. The staff evaluates the results of performance audits to determine the appropriate course of action to achieve desired results. Functions relating to fraud and abuse investigations, referrals, and prevention are handled by the Office of Compliance.~~

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 to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

~~The following positions report to the Director, Quality Improvement Director:~~

Supervisor, Quality Improvement (PQI)
Supervisor, Quality Improvement (Credentialing)
Supervisor, Quality Improvement, and Master Trainer (FSR)
QI Program Specialists
QI Nurse Specialists
Program Policy Analyst and Data Analyst
Credentialing Coordinators
- Program Specialists

Program Assistants

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

The following positions report to the Director, of Quality Analytics:
Quality Analytics HEDIS Manager
Quality Analytics Pay for Value Manager
Quality Analytics QI Initiatives Manager
Quality Analytics Analysts
Quality Analytics Project Managers
Quality Analytics Program Coordinators
Quality Analytics Program Specialists

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

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

~~Program Specialists~~
~~Program Assistant~~

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 ~~D~~directors ensures that CalOptima and its subcontracted health networks perform consistently with both CMS and state requirements for all programs. Specifically, the ~~D~~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 ~~D~~directors are ~~is~~ responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. The~~i~~s~~e~~ positions interact~~s~~ with the Board of Directors, CalOptima executives, departmental management, ~~health network~~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 Manager (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 ~~M~~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 ~~Registered Nurse (~~RN~~)~~ or ~~Licensed Vocational Nurse (~~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 (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 ~~S~~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 m~~M~~onitors 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 ~~Registered Nurse (~~RN~~)~~ or ~~Licensed Vocational Nurse (~~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 policies and procedures, and regulatory and accreditation agency requirements. The ~~M~~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 ~~Registered Nurse (~~RN~~)~~ or ~~Licensed Vocational Nurse (~~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 ~~S~~supervisor makes recommendations regarding assignments based on assessment of ~~workload, and~~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 m~~M~~onitors for documentation adequacy, including clinical documentation to make a clinical determination, ~~also~~ 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 ~~Registered Nurse (~~RN~~)~~ license or ~~Licensed Vocational Nurse (~~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 RNs draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria. ~~(S)He~~These positions audit~~s~~ 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, ~~and~~ is specific to the clinical information presented and

criteria referenced and is prepared using the appropriate threshold language template. ~~(S)He~~They works with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education

- Current and unrestricted ~~Registered Nurse 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 ~~Case Manager is~~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~~evidence-based criteria. This activity is conducted prospectively, concurrently, or retrospectively. They ~~Case Manager~~ also provide~~s~~ concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, and SRGs; and act~~s~~ as ~~a~~ liaison~~s~~ 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 ~~Licensed Vocational Nurse (~~LVN~~)~~ or ~~Registered Nurse (~~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 ~~Medical Assistant~~ perform~~s~~ ~~medical, administrative,~~ routine medical administrative tasks specific to the assigned unit and office support functions. They ~~Medical Assistant~~ also authorize~~s~~ 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~~, of~~ 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 ~~Pharmacy D~~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 ~~D~~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 ~~M~~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 ~~M~~manager develops and implements methods to measure the results of these programs, assists the Pharmacy ~~D~~director in preparing drug monographs and reports for the Pharmacy & Therapeutics 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' experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for a ~~Pharmacy & Therapeutics Committees~~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 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 ~~D~~director in preparing drug monographs and reports for the ~~Pharmacy & Therapeutics Committee~~P&T, interact frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 3 years' experience in clinical pharmacy practice including performing drug use evaluations and preparing drug monographs and other types of drug information for a ~~Pharmacy & Therapeutics Committees.~~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) 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 ~~Pharmacy & Therapeutics Committee~~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 perform all denials.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term ~~Support~~ Support Services ~~and Supports (CBAS/LTC/MSSP)~~ develops, manages and implements LTSS, including Long-Term Care (LTC) facilities, CBAS and MSSP, and staff associated with those programs. The ~~D~~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 d~~D~~evelops 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 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~~ Support Services ~~and Supports, RN~~ (CBAS/LTC) ~~The Manager~~ is expected to develop and manage the LTSS department's work activities and personnel. The ~~M~~manager ~~will~~ ensures that services standards are met, and operations are consistent with ~~the health plan's~~CalOptima's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service for CalOptima's members who are eligible for and/or receiving LTSS. ~~The~~ This ~~Manager~~ 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 networks, and other internal and external customers in a professional and competent manager. The ~~M~~manager ~~will~~ works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTC 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~~ Support Services ~~and Supports, RN,~~ (CBAS/~~,~~ LTC) ~~The Supervisor~~ 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. The~~is position~~ ~~Supervisor~~ 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 ~~S~~supervisor ~~will be resolving~~ resolves member~~s~~ and provider~~s~~ issues and barriers, ensuring excellent customer service. Additional responsibilities include: managing staff coverage in all areas of LTSS to complete assignments, and ~~orienting~~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~~ Support Services ~~and Supports~~ (MCM LTSS) ~~(RN/LVN)~~, are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, ~~provides~~ providing coordination of care, and ~~provides~~ 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, ~~National Committee for Quality Assurance (~~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 ~~MCM LTSS~~ provide~~s~~ case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. These ~~MCM LTSS is~~positions are the subject matter experts and acts as ~~a~~ liaisons to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience and Education

- A current and unrestricted RN 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 is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. The~~i~~s ~~CBAS Program Manager~~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 ~~CBAS Program M~~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 support for BHI operations:

~~**Manager, Behavioral Health** implements, manages and monitors contractual relationships with entities providing behavioral health services to CalOptima members. S/he coordinates activities between CalOptima staff, contracted providers, and health networks by providing guidance and decision support when appropriate. The position represents CalOptima and interacts with the County of Orange, contracted organizations and providers, health networks, and other stakeholders in a manner that promotes collaborative working relationships.~~

~~Experience & Education~~

- ~~Master's degree in Health Administration, Social Work, Psychology, Public Health, or other related degree is required.~~
- ~~2+ years of manager or director level experience in managed care environment, with specific experience in managing the behavioral health benefit for members covered by Medicare, Medi-Cal and/or Drug Medi-Cal.~~
- ~~3+ years of experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program.~~
- ~~Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).~~
- ~~Experience in managing Autism Spectrum Disorder Services in a Managed Care environment.~~
- ~~Experience in developing policies and procedures to meet federal and state regulatory requirements.~~
- ~~Experience in developing sound and responsible business plans and financial models.~~

~~**Manager, Behavioral Health, Clinical** is responsible for overseeing the clinical operation of CalOptima's Behavioral Health. S/He ensures the delivery of quality and consistent clinical assessment and referrals in accordance with CalOptima policies and procedures. The manager collaborates with other internal CalOptima departments to ensure all regulatory requirements are met. S/He assists the Director of Behavioral Health Services in developing and implementing behavioral health initiatives and projects. S/He represents CalOptima interacting with the County of Orange, contracted organizations and providers, health networks, and other stakeholders in a manner that promotes collaborative working relationships.~~

Experience & Education

- Master's degree in Social Work, Clinical Psychology, Marriage and Family Therapy or other related degree is required.
- Licensed (LCSW, LMFT, or Licensed Psychologist) is required.
- 4+ years of supervisor or manager level experience in managed care environment, with specific experience in providing telephonic behavioral health assessment and triage required.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).
- Experience in developing policies and procedures to meet federal and state regulatory requirements.
- Experience in developing sound and responsible business plans and financial models.

Clinicians, Behavioral Health assist and monitor clinical service relationships with practitioners providing behavioral health services to CalOptima members. The position coordinates activities between CalOptima staff, contracted providers, and health networks by providing guidance and support.

Experience & Education

- Advanced degree required such as a Master's degree in Social Work, Clinical Psychology, Marriage and Family Therapy or related field of study is required.
- License preferred.
- Minimum 5-6 years of experience is required.
- Strong written and analytical skills required.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialists are responsible for assisting members with behavioral health care management needs, which includes, but not limited to, securing behavioral health appointment for members, following up with members before and after appointment, providing member information and referring to community resources, conducting utilization review, and assisting members in navigating the mental health system of care. This position acts as a consultative liaison to assist members, health networks and community agencies to coordinate behavioral health services.

Experience & Education

- High school diploma or equivalent 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.
- 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.

Manager, Behavioral Health (BCBA) is responsible for managing Bbehavioral Hhealth Ttreatment (BHT) services, including Aapplied Bbehavior Aanalysis (ABA), for members that meet medical necessity criteriadiagnosed with Autism Spectrum Disorder (ASD). The Mmanager oversees will oversee Ccare Mmanagers who review assessments and treatment plans submitted by

providers for adherence to BHT~~ASD~~ "best practice" guidelines. ~~-~~The ~~M~~manager designs~~will design~~ and implements processes to ensure effective delivery of BHT~~ABA~~ services. This position ~~Manager will~~ 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.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- Licensed (LCSW, LMFT, Licensed Psychologist) is preferred.
- 4+ years of supervisor or manager level experience in clinical management of ABA services is required.
- 3+ years of experience providing ABA therapy to children diagnosed with ASD is required.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).

Experience in developing policies and procedures to meet federal and state regulatory requirements.~~Experience in developing policies and procedures to meet federal and state regulatory requirements.~~

-

Supervisor, Behavioral Health, 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

- 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 (Behavioral Health) 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 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.

- Active CCM certification preferred.
- Managed care experience preferred.
- Experience with ABA preferred

Care Manager ~~(BCBA)~~ is responsible for the oversight and review of BHT~~ABA~~ services offered to members that meet ~~with ASD, including screening, triaging, and assessing members to determine appropriate level of care based on~~ medical necessity criteria. The ~~Care M~~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~~community-based setting. The ~~Care M~~manager ~~will~~ 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 BCBA-D is required.
- 4+ years providing ABA therapy to children diagnosed with ASD is required.
- Possess 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~~diagnosed with ASD~~ seeking BHT services, including ABA. ~~The~~ This ~~Member Liaison Specialist will~~position assists members in linking ~~ASD related behavioral health~~ 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 system of care. ~~-~~This position will act as a consultative liaison to assist members, health networks and community agencies to coordinate ~~ASD related behavioral health~~ 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.

~~**Supervisor, Behavioral Health, UM**~~

~~The Supervisor is responsible for the utilization management (UM) functions within the Behavioral Health IntegrationBHI Ddepartment. He/sheThe 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 beserves as a resource to staff regarding CalOptima policies and procedures. The Ssupervisor, and is responsible for~~

regulatory requirements governing authorization processing and monitoring utilization patterns. The position directly supervises the Mmedical Ccase Mmanagers.

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 Registered Nurse (RN) or Licensed Clinical Social Worker (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 Applied Behavior AnalysisABA preferred

Medical Case Managers (Behavioral Health)

Medical Case Manager isare responsible for the oversight and review of ABA services offered to members that meet the medical necessity criteria. The Medical Case Mmanager 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 Medical Case Mmanager 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 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.
- Active CCM certification preferred.
- Managed care experience preferred.
- Experience with Applied Behavior AnalysisABA 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; and.
- Seniors and Persons with Disabilities Awareness Training;.

- OneCare and OneCare Connect 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 supervise the UM process and all medical necessity decisions. 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 health benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure~~. This licensure is specific to~~ 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~~:~~

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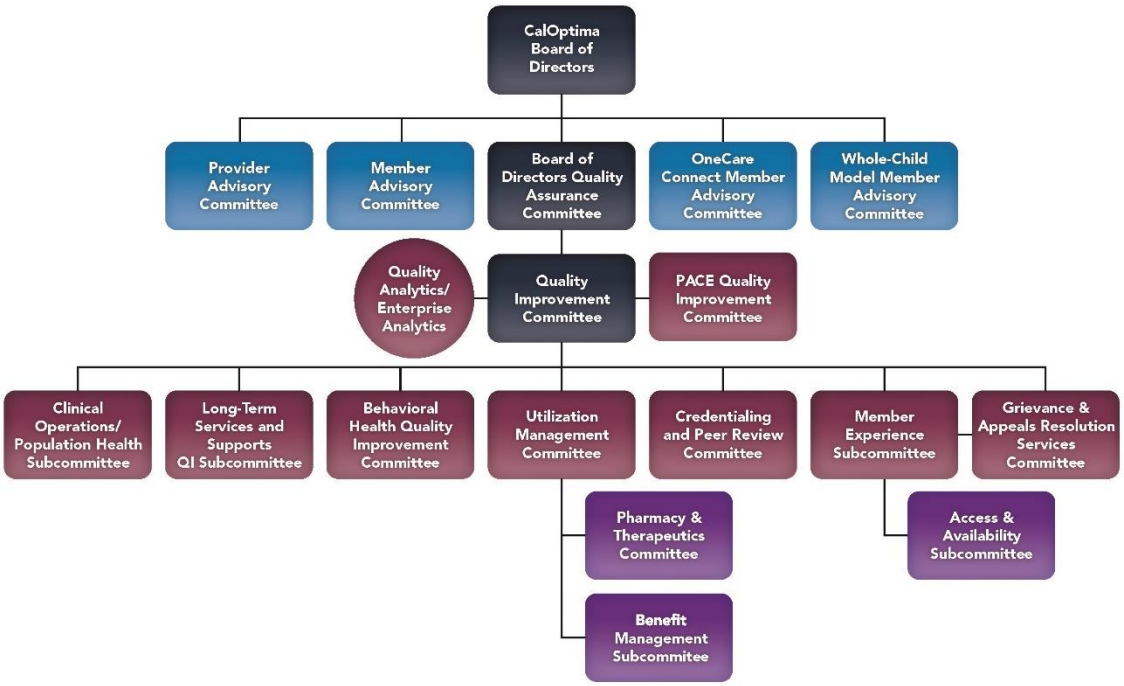
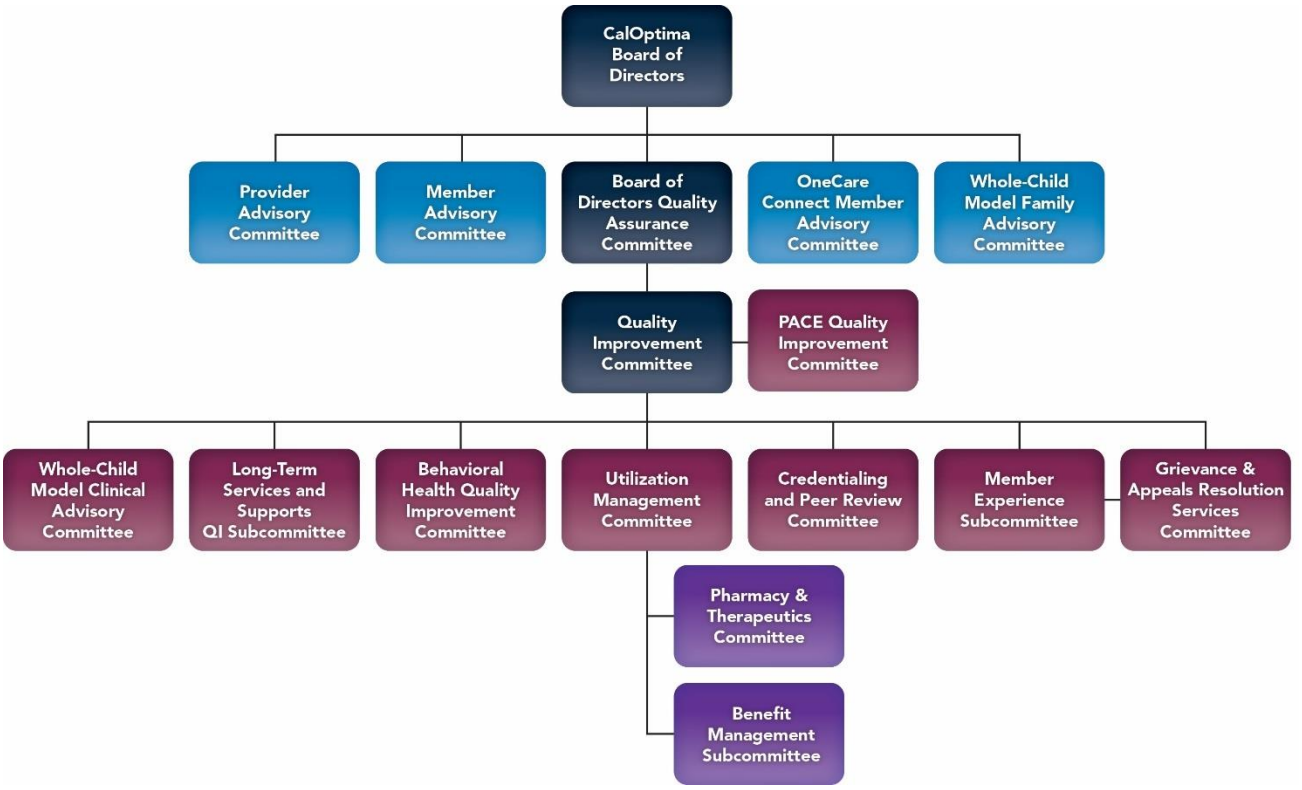
- ~~T~~he percentage ~~of~~ or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

COMMITTEE STRUCTURE





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Utilization Management Committee (UMC)

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

The UMC monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, and MBHOss to identify areas of under or over utilization that may adversely impact member care and is
~~The UMC is~~ responsible for the annual review and approval of medical necessity criteria and protocols, ~~and~~ the UM ~~Program,~~ 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 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 ~~S~~specialist, t~~T~~he ~~D~~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. ~~Daily o~~Oversight and operating authority of UM activities is delegated to the UMC which reports up through CalOptima's 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 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 ~~D~~delegated ~~Health Networks~~HN~~;~~.
- Oversees the UM activities and compliance with federal and state statutes and regulations, ~~and~~as well as contractual and NCQA requirements that govern the utilization management process~~;~~.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UM Work Plan 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 ~~Utilization Management~~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.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

Direct Subcommittee Reports:

- Benefit Management Subcommittee (BMSC)
- ~~Pharmacy and Therapeutics Subcommittee (~~P&T~~)~~
-

Departments Reporting Relevant Information on ~~Utilization Manage~~UM~~ment~~ Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- ~~Utilization Management~~UM Workgroup
- ~~Long Term Services and Support~~LTSS
-

- Reports to the ~~Quality Improvement Committee (~~QIC~~)~~ on a quarterly basis; communicates significant findings and makes recommendations related to UM issues.

~~UMC Scope~~

- ~~Oversees the UM activities of CalOptima regarding compliance with federal and state statutes and regulations, and contractual and NCQA requirements;~~
- ~~Reviews and approves the UM Program Description on an annual basis;~~ ~~Approves the use of medical necessity criteria;~~
- ~~Reviews and approves the UM Work Plan on an annual basis;~~
- ~~Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects;~~
- ~~Reviews trends and/or utilization patterns presented at UMC and makes recommendations for further action;~~
- ~~Examines 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;~~
- ~~Communicates significant findings and recommendations related to UM issues to the QIC;~~
- ~~Identifies opportunities where UM data can be utilized in the development of quality improvement activities and submitted to the QIC for recommendations;~~
- ~~Provides feedback to the QIC regarding effectiveness of CalOptima's P4P programs;~~
- ~~Report's findings of UM studies and activities to the QIC;~~ and
- ~~Liaisons with the QIC for ongoing review of quality indicators.~~

UMC Membership

Voting Members:

- ~~Chief Medical Officer (~~CMO~~)~~
- ~~CalOptima~~ Medical Director ~~Utilization Management~~UM
- ~~*Six (6) participating Practitioners from the community~~
- ~~**CalOptima~~ Medical Director Behavioral Health*
- ~~Executive Director Clinical Operations~~
- Medical Director Senior Programs
- Medical Director Quality and Analytics
- Executive Director, Clinical Operations
- Six participating practitioners from the community**

~~~~ Behavioral Health ~~P~~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 ~~P~~practitioners.~~-~~ At least ~~6~~six outside practitioners are assigned to the committee to ensure that at least ~~3~~three are present each meeting as part of the quorum requirements.

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

The UMC is supported by:

- Director, ~~Utilization Management~~UM
- Director, Quality Improvement
- Director, Pharmacy

- Manager, Prior Authorization
- Manager, Concurrent Review

~~**UMC Members**~~

~~The UMC actively involves several active network practitioners as available and to the extent that there is not a conflict of interest. CalOptima's UMC is chaired by the UM Medical Director and is comprised of the following voting members:~~

- ~~CMO;~~
- ~~Deputy CMO;~~
- ~~Executive Director, Clinical Operations;~~
- ~~Six (6) participating Practitioners from the community;~~
- ~~CalOptima Medical Director of Behavioral Health;~~
- ~~CalOptima Medical Director of Senior Programs;~~
- ~~CalOptima Medical Director of Quality and Analytics;~~
- ~~CalOptima Medical Director of Prior Authorization;~~
- ~~CalOptima Medical Director of Concurrent Review;~~
- ~~Director, Utilization Management;~~
- ~~Director, Quality Improvement;~~
- ~~Director, Pharmacy;~~
- ~~Manager, Prior Authorization; and~~
- ~~Manager, Concurrent Review~~

~~**Quorum**~~

~~A quorum consists of fifty percent (50%) plus one (1) of the voting members, with at least three (3) non CalOptimanon-CalOptima employees / community participants. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.~~

Benefit Management Subcommittee (BMSC)

The ~~Benefit Management Subcommittee~~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.~~; and~~
- ~~Revise~~ Revising and ~~update~~ updating CalOptima's authorization rules.
- ~~Makes~~ Making recommendations regarding the need for prior authorization for specific services~~;~~.
- ~~Clarifies~~ Clarifying financial responsibility of the benefit, when needed.
- ~~Recommends~~ Recommending benefit decisions to the UMC~~; and~~.
- ~~Communicates~~ Communicating benefit changes to staff responsible for implementation.

BMSC Members

The sSubcommittee membership consists of the following:

- Medical Director, Utilization Management- Chairperson;
- Executive Director, Clinical Operations;
- Director, ~~Utilization Management~~UM;
- Director, Claims Management;
- Director, Claims~~; and~~
- Director, Coding Initiatives.

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

Behavioral Health Quality Improvement Committee (BHQIC)

The purpose of the ~~Behavioral Health Quality Improvement Committee~~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~~; and~~.
- 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 ~~N~~network ~~P~~provider satisfaction study results when implementing quality activities;.
- Maintain compliance with evolving NCQA accreditation standards;.
- Communicate results of clinical and service measures to ~~N~~network ~~P~~providers~~; and~~.
- Document and report all monitoring activities to appropriate committees.

BHQIC Members

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

- Chief Medical OfficerCMO/ Deputy Chief Medical Officer;
- Executive Director, Clinical Operations;
- Medical Director, Behavioral Health Integration;
- Director of Behavioral Health IntegrationServices;
- Medical Director, Medical Management;
- Medical Director, Utilization ManagementUM;
- Executive Director, Quality and Analytics;
- Medical Director, Orange County Health Care AgencyOC HCA;
- Medical Director, Managed Behavioral Health Organization;
- Medical Director, Health Network; and
- Medical Director, Regional Center of Orange County.

The Ccommittee may permit participation by other CalOptima staff or outside guests with relevant expertise and experience. The BHQIC meets quarterly at a minimum, or 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 reducing reduce duplicate 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 cChairman of the LTSS QISC is the Medical Director, Senior Programs, ~~who is responsible for chairing the committee.~~
- ~~T~~and the LTSS QISC ~~includes~~ invites the following participants:
  - Nursing Facility Administrators~~;~~
  - CBAS Administrators~~;~~
  - OC SSA, Deputy Director or Designee~~;~~
  - MSSP, Site Director or Designee~~;~~
  - ~~Chief Medical Officer/Deputy Medical Officer;~~CMO
  - Medical Director, QI and Analytics~~;~~
  - Medical Director, UM~~;~~
  - Executive Director, Clinical Operations~~;~~
  - Executive Director, Quality Analytics~~;~~
  - Manager(s), LTSS~~; and~~
  - Director, LTSS~~.~~

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

~~**The LTSS QISC meets at least quarterly**~~

INTEGRATION WITH THE QUALITY IMPROVEMENT PROGRAM

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

- 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 QIC reports to the Board QAC.~~
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- ~~The~~The QIC reports to the Board QAC.

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 ~~Utilization Management Committee~~UMC or who otherwise make decisions on utilization management, 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, 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 ~~A~~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 ~~Utilization Management~~UM Program, Case Management Program, Behavioral Health Program, Managed LTSS Programs, ~~Pharmacy & Therapeutics (~~P&T~~) Program~~ Committee, Quality Improvement~~I~~, Credentialing, Compliance, and Audit and Oversight ~~Programs~~ 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 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 ~~or Credentialing~~ 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~~; and~~
- ~~Services provided by local public health departments.~~
-

UM Process

The UM process encompasses the following program components: referral/prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination, and second opinions. All approved services must meet ~~be~~ medical~~ly~~ necessity criteria. ~~ary.~~ 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 ~~D~~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 ~~(Medi-Cal)~~and the Centers for Medicare and Medicaid Services (CMS).~~,~~ ~~a~~ A variety of program documents, regulations, policy letters and all ~~the Center for Medicare and Medicaid Services~~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~~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 program Committee's reporting structure accurately reflect CalOptima's 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 Committees Charters.

The CalOptima UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer~~,~~; Medical Director(s) of UM~~,~~; ~~the~~ Executive~~,~~ Director~~,~~ ~~of~~ Clinical Operations~~,~~; ~~the~~ UMC and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the UM Program and UM Work Plan~~, s, which are presented annually to the QIC as part of CalOptima's Delegation Oversight Program. The QIC then reviews and approves or does not approve the delegate's UM Program and Work Plans.~~

REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

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 and the State of California for Medi-Cal, ~~OneCare~~ OC and ~~OneCare Connect~~OCC. Medically necessary means all covered services or supplies that:

- Are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury;
- ~~a~~Are appropriate and needed for the diagnosis or treatment of a member's medical condition; ~~.~~
- ~~a~~Are provided for the diagnosis, direct care, and treatment of the member's medical condition; ~~.~~
- ~~m~~Meet the standards of good medical practice in the local area;~~;~~
- Are consistent with current evidence-based clinical practice guidelines; and ~~and~~.
- A~~a~~re not mainly for the convenience of the member or the doctor.

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 other appropriate health care professionals, review and determine all final denial or modification decisions for requested medical and behavioral health 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~~;~~
- Concurrent/Continued Stay Review for selected conditions~~;~~
- Discharge Planning Review~~;~~
- Retrospective Review~~;~~
- Evaluation for potential transplant services for health network members~~;~~
- ~~Identification of Opportunities for Case Management, Disease Management or Health Education of CalOptima 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 characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological situation
    - Home environment, when applicable
    -
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action per CalOptima Policy and Procedure, GG.1508, Authorization and Processing of Referrals;.
- Reasons for decisions are clearly documented in the medical management system;.
- 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 a copy of the specific criteria utilized.

The ~~following~~ information that may be used to make medical necessity determinations ~~including~~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 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, ~~of~~ Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management ~~departments~~ 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 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 select 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 List. This list is accessible on the CalOptima website at www.caloptima.org.~~

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 ~~appearing 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 ~~the health networks~~providers and processed electronically. Some r~~R~~eferrals 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 ~~as noted on the Prior Authorization Required List~~.

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 ~~which~~ that require specialized medical care over a prolonged ~~period of time~~period can request and obtain access to ~~S~~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 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 a statement to all 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. 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

The Pharmacy Management Program 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 Pharmacy & TherapeuticsP&T Committee (P&T) and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals, andpharmaceuticals, andpharmaceuticals 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 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 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 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~~ pharmacist or ~~CalOptima~~ Medical Director. In addition, final decisions for requests that are outside of the available criteria must be made by a CalOptima ~~P~~pharmacist or ~~CalOptima~~ 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.

~~OneCare/OneCare Connect~~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 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.

BEHAVIORAL HEALTH DETERMINATIONS

Medi-Cal

CalOptima's Behavioral Health Integration department performs prior authorization review for BHT services and psychological testing. Prior authorization requests are reviewed by behavioral health 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).

The behavioral health UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may only be made by a CalOptima Licensed Psychologist or Medical Director.

CalOptima's written notification of behavioral health 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 UM denial decisions.

~~OneCare/OneCare Connect~~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).

~~Utilization Review of Supplemental Dental Benefits (OC, OCC)~~

~~Utilization Review of Supplemental Dental Benefits available for OneCare and OneCare Connect Members is delegated to Liberty Dental Denti-Cal. Oversight of the UM process is performed by CalOptima's Audit and Oversight Department to ensure compliance with contractual and regulatory requirements.~~

~~Preventive and Clinical Practice Guidelines (CPG)~~

UM Criteria

~~Clinical Guidelines are developed and implemented via the QIC, and assist in making health care decisions and improving the quality of care provided to members. Medication use guidelines have been developed that are reviewed by the P&T Committee, which includes outside physician and pharmaceutical participants, whose recommendations are forwarded to the QIC for review and approval. These guidelines are posted on the CalOptima website. Additional condition specific guidelines are in development, and are based on a compilation of current medical practices researched from current literature and professional expert consensus documents. Guidelines are reviewed and updated at least annually by the respective committees. These standards for patient care are to be used as guidelines, and are not intended to replace the clinical medical judgment of the individual physician. CPGs are shared with the delegated Health Networks as they are approved.~~

~~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.~~

~~UM criteria are nationally recognized, evidence based standards of care and include input from recognized experts in the development, adaption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate.~~

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 and review of the criteria. UM criteria and the policies for application are reviewed and approved at least

~~annually, and~~annually and updated as appropriate. Such criteria and guidelines include, but are not limited to:

~~uses the following criteria sets for all medical necessity determinations:~~

- ~~-~~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~~, and~~
- ~~•~~
- 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 ~~California Children's Services~~CCS and Whole Child Model.

~~Medi-Cal and Medicare Manual of Criteria;National and Local Coverage Determination Guidelines.~~

- ~~•~~
- ~~MCG — Evidence-based nationally recognized criteria;~~
- ~~National Comprehensive Cancer Network (NCCN) Guidelines;~~
- ~~Centers of Excellence Guidelines;~~
- ~~Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP) and American Heart Association Guidelines;~~
- ~~CalOptima Criteria for outpatient behavioral health services;~~
- ~~CalOptima Medical Policy and Medi-Cal Benefits Guidelines;~~
- ~~National and Local Coverage Determination Guidelines.~~
- ~~National Guideline Clearinghouse~~
- ~~Medicare Part D: CMS-approved Compendia~~

Delegated ~~H~~health ~~N~~networks 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 Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	PA Nurse Reviewer**	Medical Director / Physician Reviewer
Chemotherapy – all request types reviewed by ~~Ph D~~	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines		~~X~~	X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
~~Dialysis~~	~~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
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

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	PA Nurse Reviewer**	Medical Director / Physician Reviewer
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals	~~RCOC Referrals~~	X	
Transplants	DHCS Guidelines/ MCG	~~Referral~~	X	X

* If Medical Necessity criteria is not met, the request is referred to a PA Nurse Reviewer for further review and determination.

** If Medical Necessity criteria is not met, the request is referred to a ~~the~~ Medical Director / Physician Reviewer for further review and determination.

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

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer
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.

Medi-Cal Behavioral Health Services Authorization Types

Authorization Type*	Criteria Utilized	Medical Case Manager ~~Medical Assistant~~	Care Manager (BCBA)	Medical ~~Director /~~ Physician Reviewer / Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal Manual, CalOptima policy	X	~~X~~	X
Behavioral Health Treatment (BHT) services	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 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 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, ~~OneCare, OneCare Connect~~OC and OCC

CalOptima's P&T Committee and Benefit Management s~~S~~ubcommittee 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 UM ~~department, or~~department or may discuss the UM decision with CalOptima Medical Director. 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. 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, ~~of~~ 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, ~~of~~ 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.

Provider/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 web, 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 health 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 Director. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner.

UM Sstaff Aaccess 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 ~~SRGs Health Network~~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 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. 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. ~~Members requesting a copy of CalOptima's designated record set are not charged for the copy.~~

Sharing Information

CalOptima's UM staff share all clinical and demographic information on individual patients among various ~~divisions~~ 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/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 OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines — Medi-Cal (Excludes Pharmacy ~~r~~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, ~~M~~modify or ~~D~~deny within 5 working days of receipt of "all information" reasonably necessary and requested to render a decision but no longer 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 ~~M~~member or the ~~M~~member's provider may request for an extension, or the ~~P~~plan can provide justification upon request by the State for the need for additional information	**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

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
	and how it is in the m~~M~~ember's interest. ▪ The ~~D~~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 **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 m~~M~~ember notice of denial.		from the receipt of the request **Note:** CalOptima shall make reasonable efforts to give the ~~M~~member and ~~P~~prescribing ~~P~~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
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 Pplan determines that the standard timeframe could seriously jeopardize the me 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: ~~Requests where provider indicates, or the Hh complex care management and case management servicesealth Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.~~ ~~Additional clinical information required~~. Extension is allowed ***only*** if Mmember or provider requests the extension or the Pplan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the Mmember.	The Pplan 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 Pplan asks the Mmember, the Mmember's representative, or provider for the specific information necessary to make the decision. ▪ The Pplan gives the Mmember or Mmember's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Pplan, begins: ○ On the date when the Pplan receives the Mmember's response (even if not all of the information is provided), ***or*** ○ At the end of the time period given to the Mmember to provide the information, if no response is received from the	**Practitioner and Member:** Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination.	**Practitioner**: Within 24 hours of the decision but no later than72 hours from receipt of information that is reasonably necessary to make a determination. - **Member:** Within 2 business days of the decision[2] 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 Mmember and Pprescribing Pprovider 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
	~~M~~member or the ~~M~~member's authorized representative. **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for services where application of the time frame for making routine or non-life–threatening care determinations: ▪ ○ ~~o~~ Could seriously jeopardize the life, health or safety of the ~~M~~member or others, due to the ~~M~~member's psychological state, or ○ — In the opinion of a practitioner with knowledge of the ~~M~~member's medical or behavioral condition, would subject the ~~M~~member to adverse health consequences without the care or treatment that is the subject of the request. ○ ▪ The ~~M~~member or the ~~M~~member's provider may request for an extension, or the ~~H~~health ~~P~~plan/ ~~P~~provider ~~G~~group can provide justification upon request by the ~~S~~state for the need for additional information and how it is in the ~~M~~member's interest.	**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 ~~**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
	– Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed, and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. ○ ○ Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.		
Concurrent: Concurrent review of treatment regimen already in place, even if the health plan did not previously approve the earlier care (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the ~~M~~member's treating provider has been notified of the health plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that ~~M~~member	Within 24 hours of receipt of the request **NOTE:** The p~~P~~lan may extend decision time frame if the request to approve additional days for urgent concurrent care is related to care not approved by the ~~P~~plan previously; ~~T~~the ~~P~~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 ~~P~~plan has up to 72 hours to make a decision (NCQA UM 5) ○ A response to defer is required within 24 hours for all services that require prior authorization. ○ A decision to approve, modify, or deny is required within 72 hours, or as soon as a ~~M~~member's health condition requires, after the receipt of the request. ○ If the plan is unable to request for an extension of	**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 ~~P~~plan must notify beneficiaries at least ~~ten (~~10~~)~~ days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.

Type of Request	Decision	Notification Timeframe	
		Initial Notification (Notification May be Oral and/or Electronic)	Written/Electronic Notification of Delay, Denial or Modification to Practitioner and Member
	an urgent concurrent care within 24 hours before the expiration of the prescribed period of time or number of treatments, then the plan may treat the request as urgent preservice and make a decision within 72 hours. The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny.		
Post-Service / Retrospective Review: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Within 24 hours of making the decision	**Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination (written notification) **Member:** Within 2 business days of the decision[2] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2]
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.

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 Information Received: If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Member & Practitioner**: None specified **Member & Practitioner**: None specified	
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 (Eexcludes Pharmacy Rrequests)

Type of Request	Decision	Notification Timeframe Member and Practitioner
Standard Initial Organization Determination (Pre-Service) –If Nno Eextension Rrequested or nNeeded	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 Eextension Rrequested or Nneeded	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 Hhealth Pplan 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 Eexpedited cCriteria 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 –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. 2. ○ If submitted as expedited but	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 Hhealth Pplan 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;.

Type of Request	Decision	Notification Timeframe Member and Practitioner
	determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14-day period begins with the day the request was received for an expedited determination.	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~~; and~~. ~~—~~Provide instructions about the expedited grievance process and its timeframes. 4.
Expedited Initial Organization Determination ~~–~~If ~~N~~no ~~E~~extension ~~R~~requested or ~~N~~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** ○ Oral or written notice must be given to member and provider within 72 hours of receipt of request. ○ Document date and time oral notice is given. ○ If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request. ▪ **Denials** ○ 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. ~~○~~ ~~–~~Document date and time of oral notice. ○ 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 ~~E~~extension ~~R~~requested or ~~N~~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 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 ~~H~~health ~~P~~plan must respond to an expedited grievance within 24 hours of receipt. ***Decision Notification*** After an Extension: ▪ Approvals ○ Oral or written notice must be given to member and provider no later than upon

Type of Request	Decision	Notification Timeframe Member and Practitioner
	— 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). ▪ ~~D~~ ▪ 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.	expiration of extension. ○ 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 ○ 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. ○ Document date and time of oral notice. ○ — If only written notice is given, it must be received by member and provider no later than upon expiration of extension. ○

UM Decisions and Timeframes for Determinations — Pharmacy for Medi-Cal, OCC & OCC

~~Medi-Cal~~ ~~Clinical Decision Making~~	~~OneCare and OneCare Connect~~ ~~Clinical Decision Making~~

• ~~Performed by CalOptima UM staff for COD-A and CCN members~~
• ~~Performed by Health Network UM staff for HN members~~
  ○ ~~Requests for transplant services for HN members are performed by CalOptima UM staff~~
• ~~Qualified physician review for modifications or denials~~
• ~~Qualified psychologist or psychiatrist review for modifications or denials of behavioral health services~~
• ~~Qualified pharmacist review for pharmacy modifications or denials~~
	• ~~Performed by CalOptima UM staff for CCN members~~
	• ~~Performed by Health Network UM staff for HN members~~
	  ○ ~~For OneCare HN members Medi-Cal "wrap" benefits and requests for out of area services (SRGs only) are performed by CalOptima UM staff.~~
	• ~~Behavioral Health Determinations Performed by Managed Behavioral Health Organization~~
	• ~~Qualified physician review for any modifications or denials~~
	• ~~Qualified psychologist or psychiatrist review for modifications or denials of behavioral health services~~
	• ~~Qualified pharmacists or physician review for pharmaceutical partial approvals or denials~~

Medi-Cal Timeframes for Decision	OneCare and OneCare Connect Timeframes for Decision
Routine: 5 business days from receipt of all medically necessary information to make a determination, not to exceed 14 calendar days from receipt of request **Urgent**: 72 hours from receipt of request **Retrospective**: 30 calendar days from receipt of request	**Routine**: 14 calendar days from receipt of request **Routine Extension Needed**: May extend for an additional 14 days if additional information may result in an approval. • Provider: Within 24 hours of extension decision • Member: Within 24 hours of extension decision **Urgent:** 72 hours **Retrospective:** 30 calendar days from receipt of request

Medi-Cal Timeframes for Notification	OneCare and OneCare Connect Timeframes for Notification (non-Part D)
Routine: Provider: Verbal/ Electronic: within 24 hours of decision Written: within 2 working days of the decision, if verbal previously given Member: Verbal not required Written: (Required only for delay, modification or denial). Within 2 working days of the decision, not to exceed 14 calendar days from the receipt of the request. **Expedited (Urgent):** Provider: Verbal Electronic: within 72 hours from the receipt of the request; must include expedited appeal rights. Written (if verbal notification given): Within 2 working days of the decision Member: Verbal: not required Written: (Required only for delay, modification or denial) Within 2 working days of making the decision.	**Standard (Routine):** Provider: Written notification must be sent within three days of decision. Member: Notified of the decision no later than 2 working days from the decision, not to exceed 14 days from receipt of the request. **Expedited (Urgent):** Provider: Verbal/ Electronic: notification 72 hours from the receipt of the request; must include expedited appeal rights. Written (If verbal notification given): Within 2 working days of the decision Member: Verbal: Within 24 hours of decision Written: Within 2 working days of making the decision

Medi-Cal Timeframes for Notification (cont.)	OneCare and OneCare Connect Timeframes for Notification (non-Part D) (cont.)
Concurrent: Practitioner: Verbal/ Electronic: Within 24 hours of making the decision Written (if verbal notification): Within 2 working days of the decision. Following completion of treatment, an authorization summary is provided within 2 working days. Member: Verbal: Not required. Written: (Required only for delay, modification or denial). Within 2 working days of decision **Retrospective:** Practitioner: Verbal: not required Written: (Required only for modification or denial): Within 30 days of receipt of information necessary to make the determination Member: Verbal: Not required Written: (Required only for modification or denial): Within 30 days of receipt of information necessary to make the determination	**Concurrent:** Practitioner: Verbal/ electronic: Within 24 hours of making the decision Written (if verbal notification): Within 2 working days of the decision. Following completion of treatment, an authorization summary is provided within 2 working days. Member: Verbal: Not required. Written: (Required only for denial). Within 2 working days of decision **Retrospective:** Practitioner: Verbal: Not required Written: (Required only for denial): Within 30 days of receipt of information necessary to make the determination Member: Verbal: Not required Written: (Required only for denial): Within 30 days of receipt of information necessary to make the determination Notice requirement: CMS "Medicare Notice of Non-Coverage" including specific language for expedited appeal for expedited initial organization determination

Medi-Cal Pharmaceutical — Decision Making	OneCare and OneCare Connect 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 ~~or Pharmacy Benefits Manager~~ • Qualified pharmacist or physician review for any modifications or denials • Qualified physician review for any appeals •

Medi-Cal Pharmacy Timeframes for Determinations	OneCare and OneCare 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:** Within 24 hours a decision to approve, modify, deny or defer is required. **Expedited (Urgent) Preservice, 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 Extension Needed: Provider: Electronic/written: Within 2 business days of 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. **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 Review:** 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.

~~Medi-Cal~~ ~~Denial Letter/Member Notification~~	~~OneCare and OneCare Connect~~ ~~Denial Letter/Member Notification~~
~~State mandated "Notice of Action"~~	~~CMS mandated "Medicare Notice of Non-Coverage" including specific language for expedited appeal for expedited initial organization determination~~

Emergency Services

Emergency room services are available 24 hours/day, 7 days/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 ~~inpatient and outpatient services~~ 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 ~~P~~plan network practitioner, or ~~P~~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 ~~previously stated.~~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 Health Network shall approve or deny the Prior Authorization Request for Post-Stabilization Services within ~~thirty (~~30~~)~~ minutes of receipt of the telephone call from the Hospital for Medi-Cal members and within ~~sixty (~~60~~)~~ minutes of receipt of the telephone call from the hospital for OneCare or OneCare Connect members.~~-~~ If CalOptima or the H~~ealth N~~etwork~~ does not respond within the prescribed time frame, Medically Necessary 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.

PRIOR AUTHORIZATION SERVICES

UM Urgent/Expedited Prior Authorization Services
For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima ~~within~~ at least ~~five (~~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 ~~emergent~~ emergency or urgent care services~~. Facilities are required to notify CalOptima of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Post-stabilization services require authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required.~~

UM Routine/Standard Prior Authorization Services
CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within ~~five (~~5~~)~~ business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request.~~ A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. CalOptima makes a determination for urgent concurrent, expedited continued stay, post stabilization review or in cases for ongoing ambulatory care or if the lack of treatment may result in an emergency visit or emergency admission within 24 hours of receipt of the request for services. 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). 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.~~

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 ~~as follows per~~in accordance with CalOptima Policy and Procedure GG.1508 Authorization 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. ~~The decision, to authorize or deny, is made within thirty (30) calendar days of receipt.~~

Admission/Concurrent Review Process

Facilities are required to notify CalOptima of all inpatient admissions within ~~one (~~1~~)~~ business day following the admission. ~~-~~The admission/concurrent review process assesses the clinical status of the member~~,~~ ~~and~~ verifies the need for continued hospitalization~~,~~ ~~and~~ 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~~, and~~
- Reasons for extension of the treatment or service~~.~~

~~Post-stabilization services requires authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as described above.~~

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 ~~, disease 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 ~~CalOptima Direct (~~COD~~)~~ members
- Process for notification of hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care ~~P~~plan development and implementation
- Discharge ~~P~~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~~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 pPlanning 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 the Referral/Authorization Processing Policy and Procedure. The written notification is easily understandable 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 health 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 PROCESS

CalOptima has a comprehensive review system to address matters when Medi-Cal, OneCare or OneCare Connect members wish to exercise their right to review ~~of~~ a UM decision to deny, delay, ~~terminate~~ 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 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 ~~and Procedure~~ HH.1102: CalOptima Member Complaint and CalOptima Policy GG.1510: Appeal Process.~~Grievance and Appeals Resolution Services.~~ This process includes:

- Collection of data.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Resolution of operational or systems issues.
- 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 ~~initial~~ 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~~; however, the initial reviewer may participate in the appeal process if new or additional information is submitted~~.
The UM or CM Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The UM 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 ~~is~~ 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, ~~or~~ 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 ~~as~~ an expeditious ~~a~~ 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.

~~Fair~~ State Hearing (Medi-Cal Line of Business Only)

CalOptima Medi-Cal members have the right to request a ~~Fair~~ State Hearing from the California Department of Social Services ~~at any time during the appeals process,~~ after exhausting the appeal process. ~~or within 90 days of an adverse decision.~~ A member may file a request for a ~~Fair~~ State Hearing within 120 days from the Notice of Appeal Resolution. ~~and a request for an appeal at the same time.~~ CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State ~~Fair~~ Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution ~~resolution letter~~ 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). ~~T~~CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. ~~OneCare~~ CalOptima is notified when a request is made by a member or member representative. ~~OneCare~~ CalOptima supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and ~~OneCare~~ CalOptima of the outcome of their review. If the decision is overturned, ~~OneCare~~ 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~~, and~~.

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 Care case management program includes authorizations for the following facilities:

- ~~s~~Skilled nursing~~,~~
- ~~i~~Intermediate care, sub-acute care~~,~~
- ~~I~~intermediate care~~–~~, developmentally disabled~~,~~
- ~~I~~intermediate care~~–~~, developmentally disabled~~—~~ ~~–~~ habilitative~~, and~~
- ~~i~~Intermediate care~~—~~, developmentally disabled~~—~~ ~~–~~ nursing~~.~~

It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. An on-site visit is scheduled to assess patient'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. 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. 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~~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.

~~IHSS~~

~~CalOptima is responsible for member referral to the IHSS program (which is operated by the County of Orange) for individuals who may qualify for services. The program provides services to those members who are disabled, blind, or 65 years of age or older and are unable to live safely at home without help who meet the financial need requirement. Services are provided by a caretaker that the member hires. The County determines eligibility under the program. It also determines the number of hours that an individual can receive services. Under an MOU with the county, CalOptima works collaboratively to ensure that referrals are being made.~~

Transitions of Care (TOC)

Transitions of Care (TOC) is a ~~4 week~~ patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides ~~OneCare~~OC and ~~OneCare Connect~~OCC ~~patients~~members discharged from Fountain Valley Regional Hospital (or caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential ~~a~~ of a ~~possible~~ 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**: ~~Patient~~ Member is knowledgeable about indications that their condition is worsening and how to respond~~:~~.
- **Medication Self-Management**: ~~Patient~~ Member is knowledgeable about medications and has a medication management system~~:~~.
- **Patient-Centered Health Record**: ~~Patient~~ 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**: ~~Patient~~ 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 healthcare delivery organizations and community resources, as applicable. -

For further details of the structure, process, staffing, and overall program management please refer to the ~~2018~~ 2019 Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by CalOptima's 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~~, or CMS Center(s) of Excellence for OneCare,~~ 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, ~~and reports to the UMC to oversee the accessibility, timeliness and quality of the transplant process across networks.~~

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 ~~which~~ 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 Medicaid 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
- Readmission Rates
- ~~Used/Unused Authorizations~~
- ~~Inter-rater Reliability for all licensed staff utilizing clinical review criteria~~
- ~~Grievances — Member per 1000 per Year~~
- ~~Appeals — Member per 1000 per Year~~
- Overturn Rates — Provider per 1000 per Year
- ~~Satisfaction with Primary Care Access~~
- ~~Provider Satisfaction~~
- ~~Member Satisfaction~~
- HEDIS rates for selected measures ~~/Consumer Assessment of Healthcare Providers and Systems (CAHPS)~~
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PROGRAM EVALUATION

The UM Program is evaluated at least annually, and modifications made as necessary. The UM Medical Director and Director~~, of U~~~~tilization M~~~~anagement~~ 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 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, 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~~include, but are not limited to: member satisfaction survey results (CAHPS), member/provider complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM ~~process, and~~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.

2019 Utilization Management Program

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Tracy Hitzeman, RN, CCM
Executive Director, Clinical Operations

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2019 UM Program Description

- Defines CalOptima's structure and process for review of health care services, treatment and supplies
- Explains how services are reviewed in an effective, timely manner
- Includes the assignment of appropriate individuals for review
- Outlines monitoring processes to evaluate the effectiveness of the program and identify opportunities for improvement

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2019 UM Program Description Revisions

- Aligned program descriptions and committee references with the Quality Management Program and approved committee charter updates.
- Updated program to reflect the transition of California Children's Services program to the Whole Child Model program
- Updated description of responsibilities for various key positions
- Modified reference to CalOptima's health networks to reflect changes in participating networks since 2018

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2018 PACE Quality Assurance Performance Improvement (QAPI) Plan Evaluation

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Miles Masatsugu, MD
Medical Director

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2018 PACE QAPI Program Evaluation

- Quality Assessment Performance Improvement (QAPI) Plan Evaluation
  - Represents the analysis of the core clinical and service PACE indicators
  - Analysis provides guidance on opportunities for improvement in 2019

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2018 Accomplishments

- Membership growth to 299 participants
- Only two participants were in LTC in 2018
- Completed a successful DHCS/CMS Joint Audit and two successful DHCS Level of Care Audits
- 98% Influenza immunization rate
- Infection rates lower than national benchmarks
- 95% medication reconciliation rate following a hospital discharge
- 100% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed

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2018 Accomplishments

- Diversity of participants and staff
  - Participants
    - Speak 10 unique languages
    - 11% utilize English as their second language
  - PACE staff
    - 80% of PACE staff are bilingual/multilingual
    - Speak 10 unique languages

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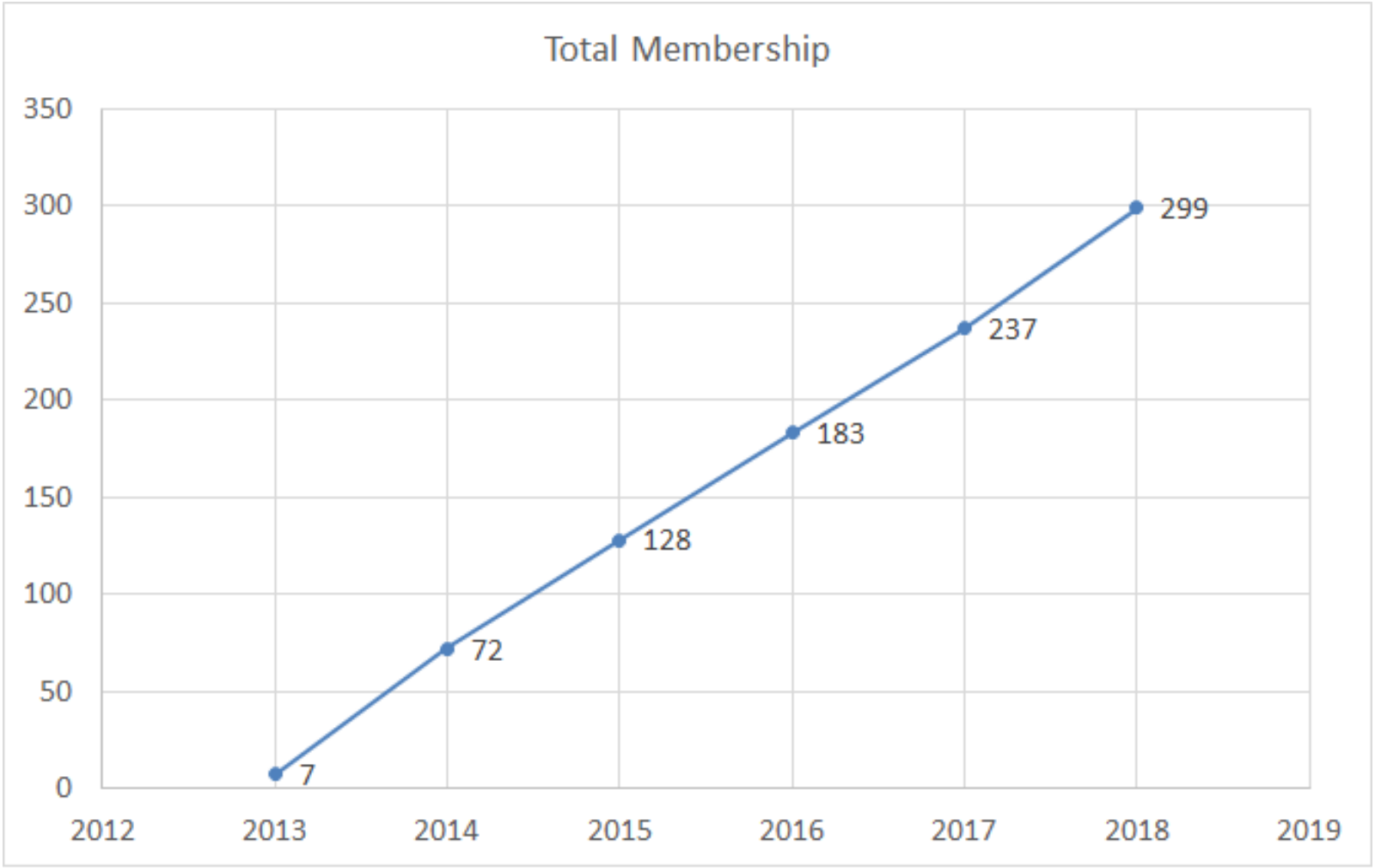
Membership Growth: 2013–2018



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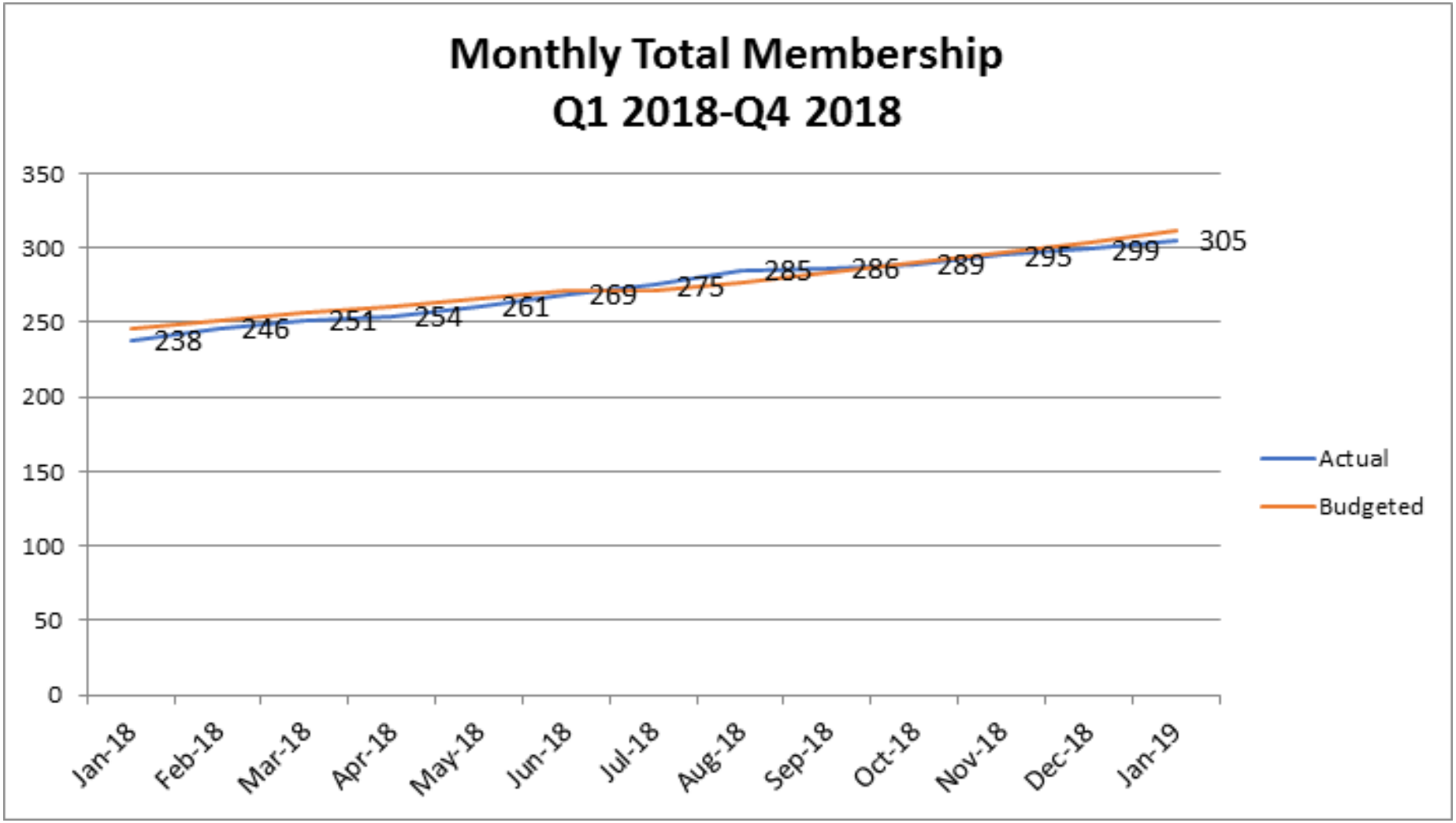
2018 Monthly Membership



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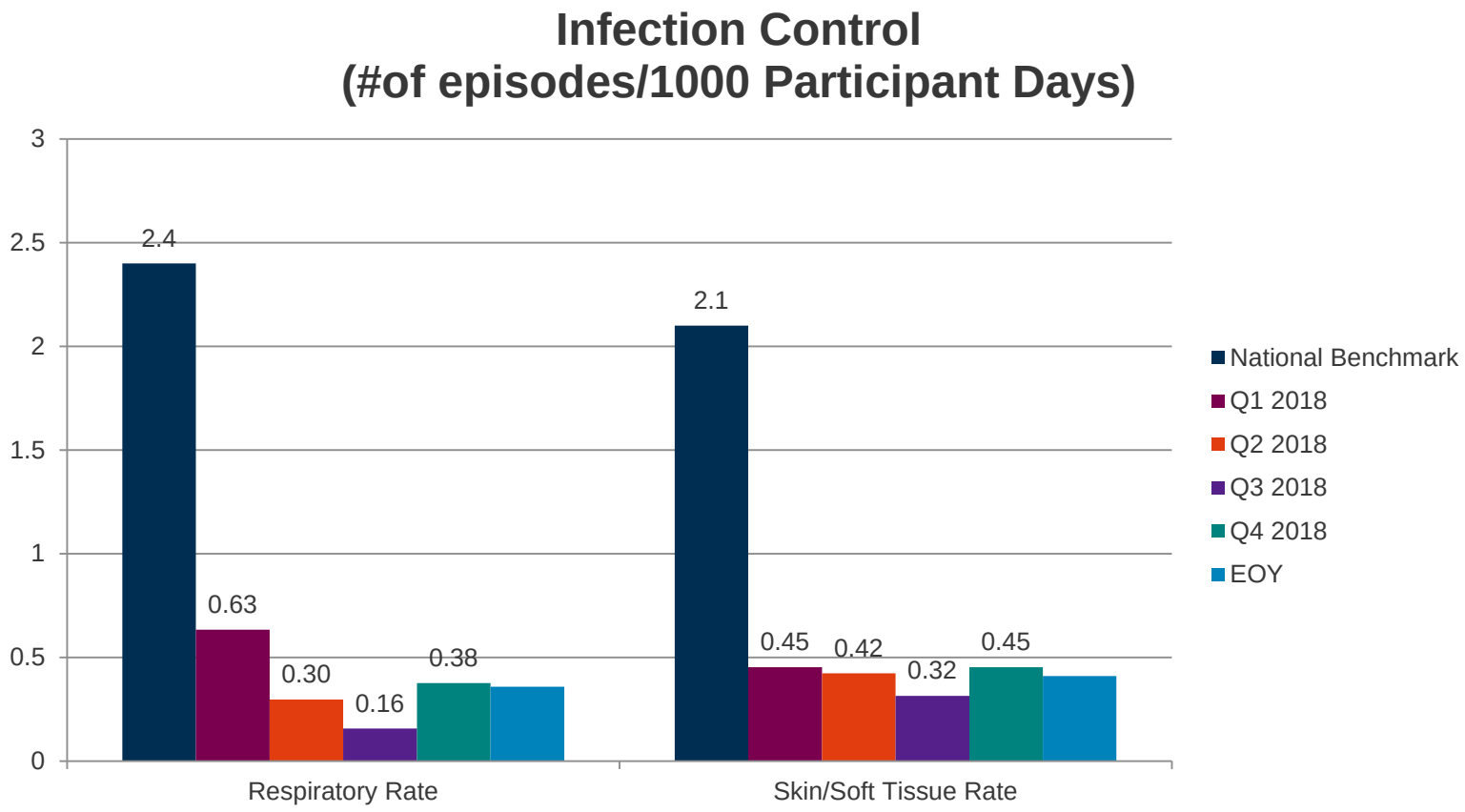
Element 5: Infection Control (Episodes per 1000 Participant Days)



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Elements 6–9: Care for Older Adults

			2018 Star Cut Points			
	2018 PACE Rate	2017 OCC Rate	2 Star	3-Star	4-Star	5-Star
Advanced Care Planning	**100%**	24.98%	N/A	N/A	N/A	N/A
Medication Review	**100%**	29.66%	59% to 79%	79% to 88%	88% to 93%	>93%
Functional Status Completion	**100%**	28.69%	46% to 67%	67% to 78%	78% to 92%	>92%
Pain Screening	**100%**	30.48%	40% to 62%	62% to 80%	80% to 94%	>94%

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Elements 10–12: Comprehensive Diabetes Care (CDC)

			Quality Compass 2017 HEDIS Percentiles			
	2018 PACE Rate	2017 OCC Rate	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Annual Diabetic Exams	**90%**	67%	>63.02%	>70.91%	>78.41%	>83.54%
Nephropathy Monitoring	**96%**	95%	>94.16%	>95.86%	>97.48%	>98.88%
Blood Pressure Control	**100%**	29%	27% to 68%	68% to 77%	77% to 90%	90%

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Elements 13–15: Potential Harmful Drug/Disease Interactions in the Elderly

Lower is better

			Quality Compass 2017 HEDIS Percentiles			
	2018 PACE Rate	2017 OCC Rate	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Falls plus TCA or Antipsychotic	**48%**	42.43%	<52.52%	<46.88%	<42.70%	<37.25%
Dementia + Tricyclic Antidepressants or anticholinergic Agents	**24%**	48.05%	<50.78%	<45.37%	<40.61%	<36.13%
Chronic Renal Failure + NSAID	**<1%**	25.24%	<14.36%	<9.40%	<6.38%	<3.85%

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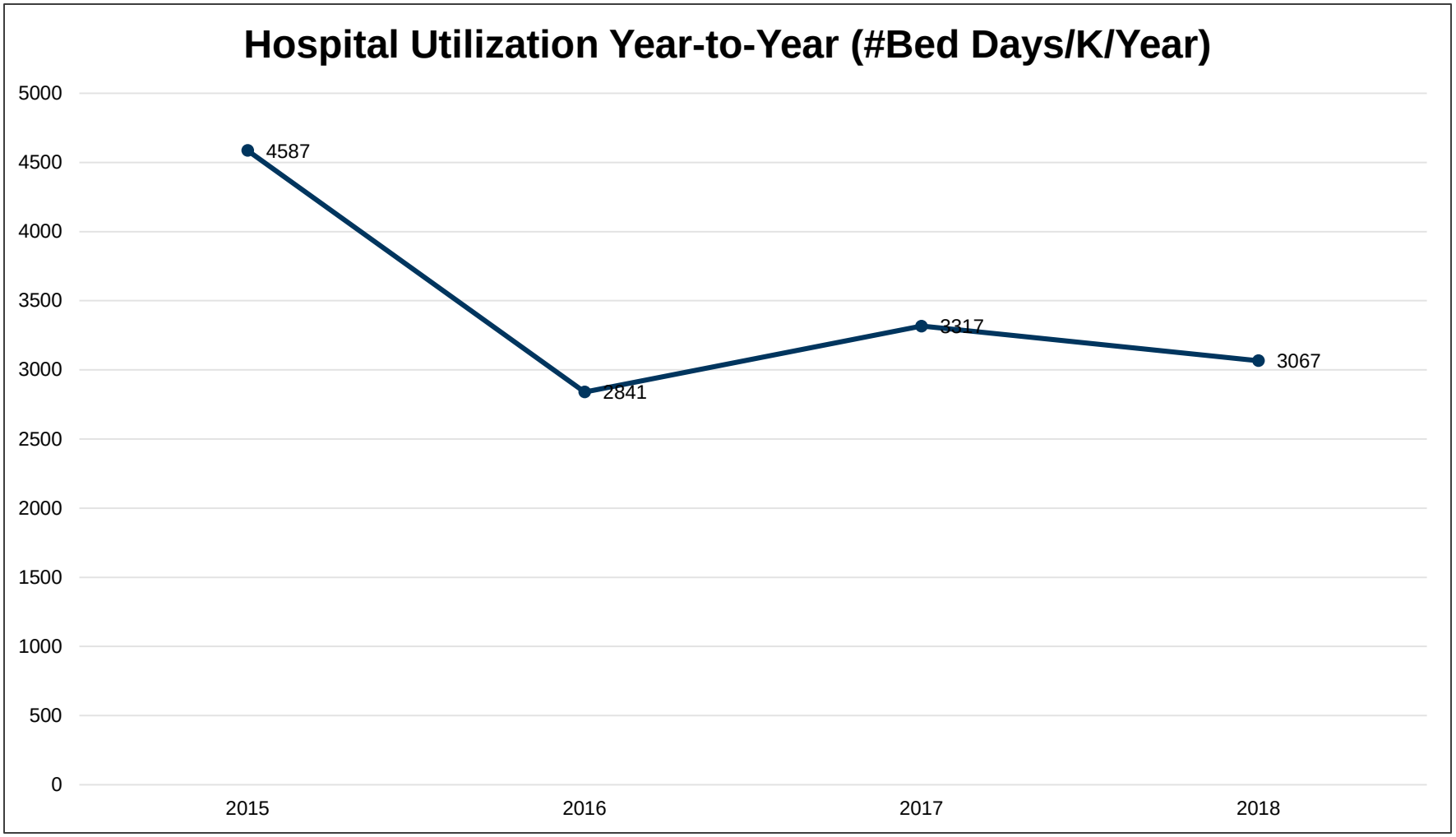
Element 18: Hospital Bed Days (Goal: <2590 Bed Days/1000/Year)



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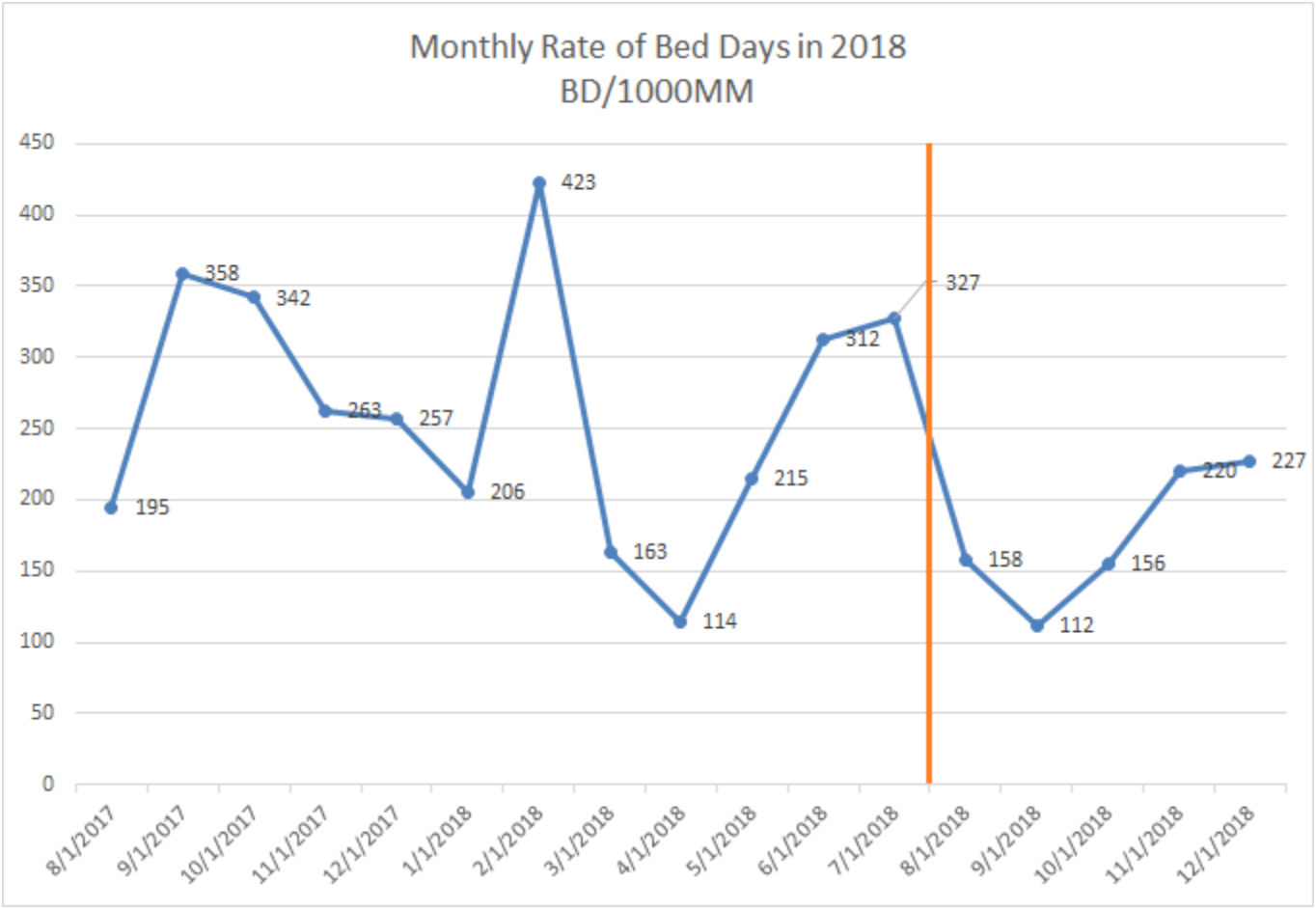
Element 18: Hospital Bed Days (ER Diversion Program Impact)



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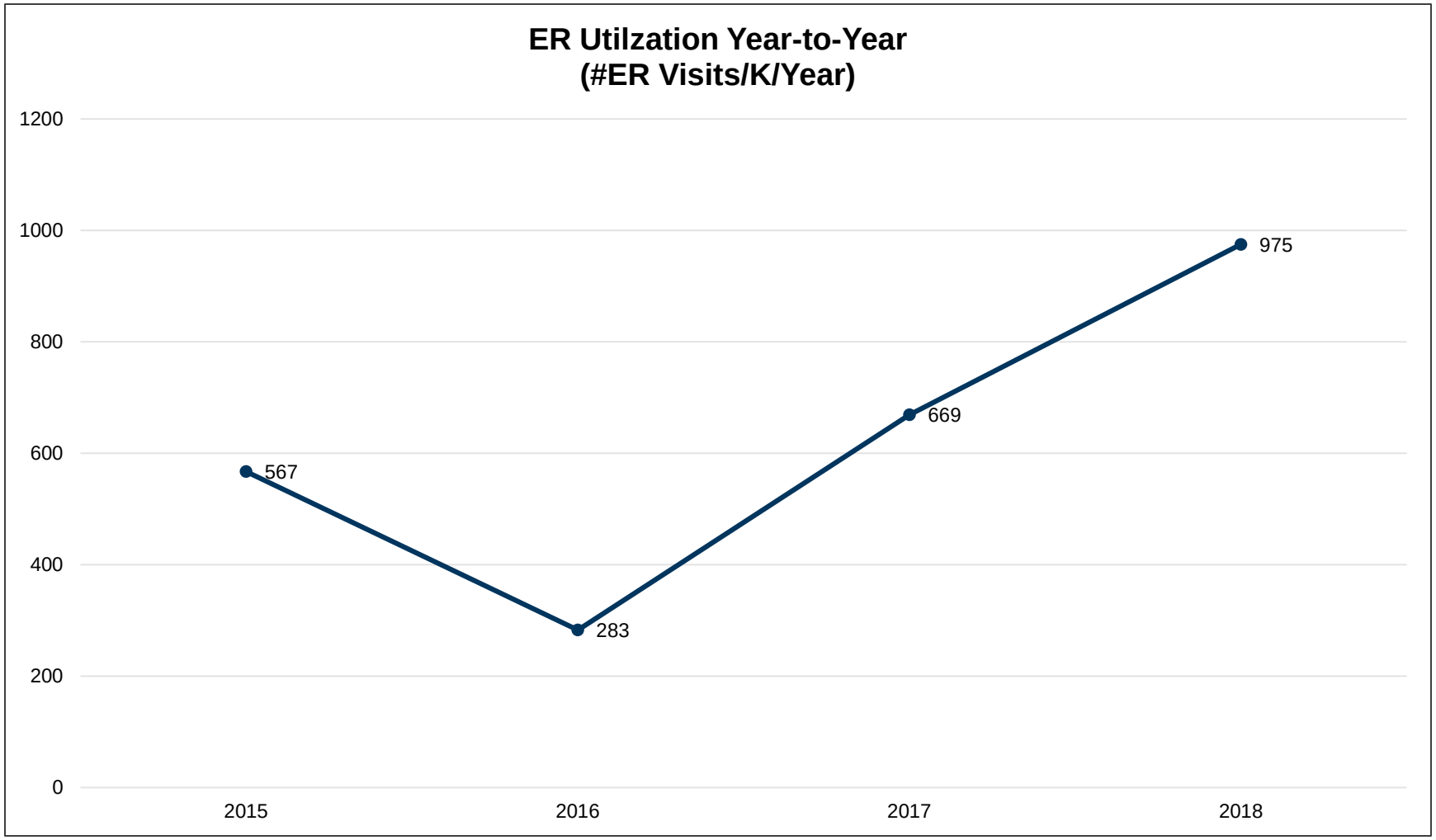
CalOptima A Public Agency Better. Together.

Element 19: ER Utilization (Goal <458 Visits/1000/Year)



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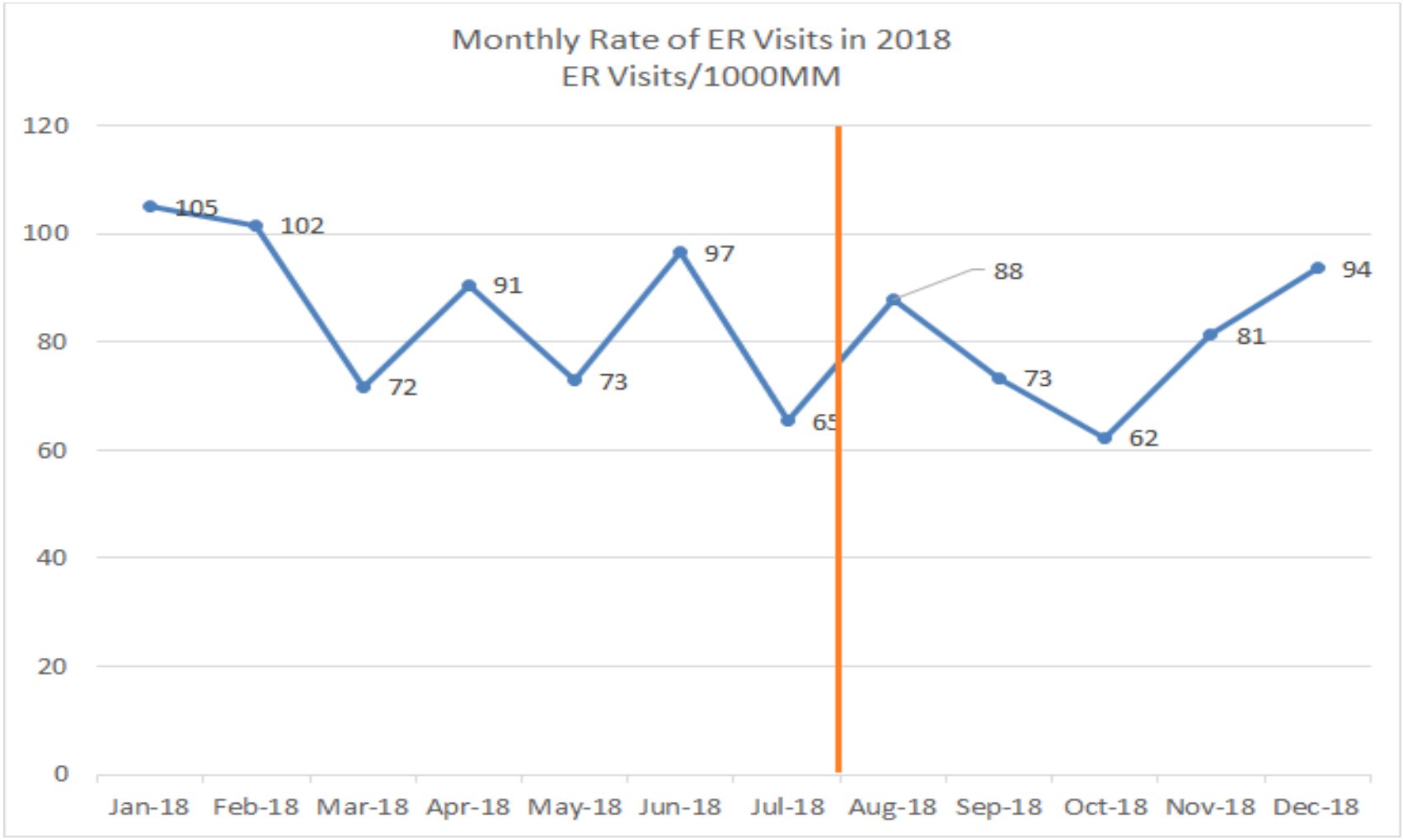
Element 19: ER Utilization Monthly Variations



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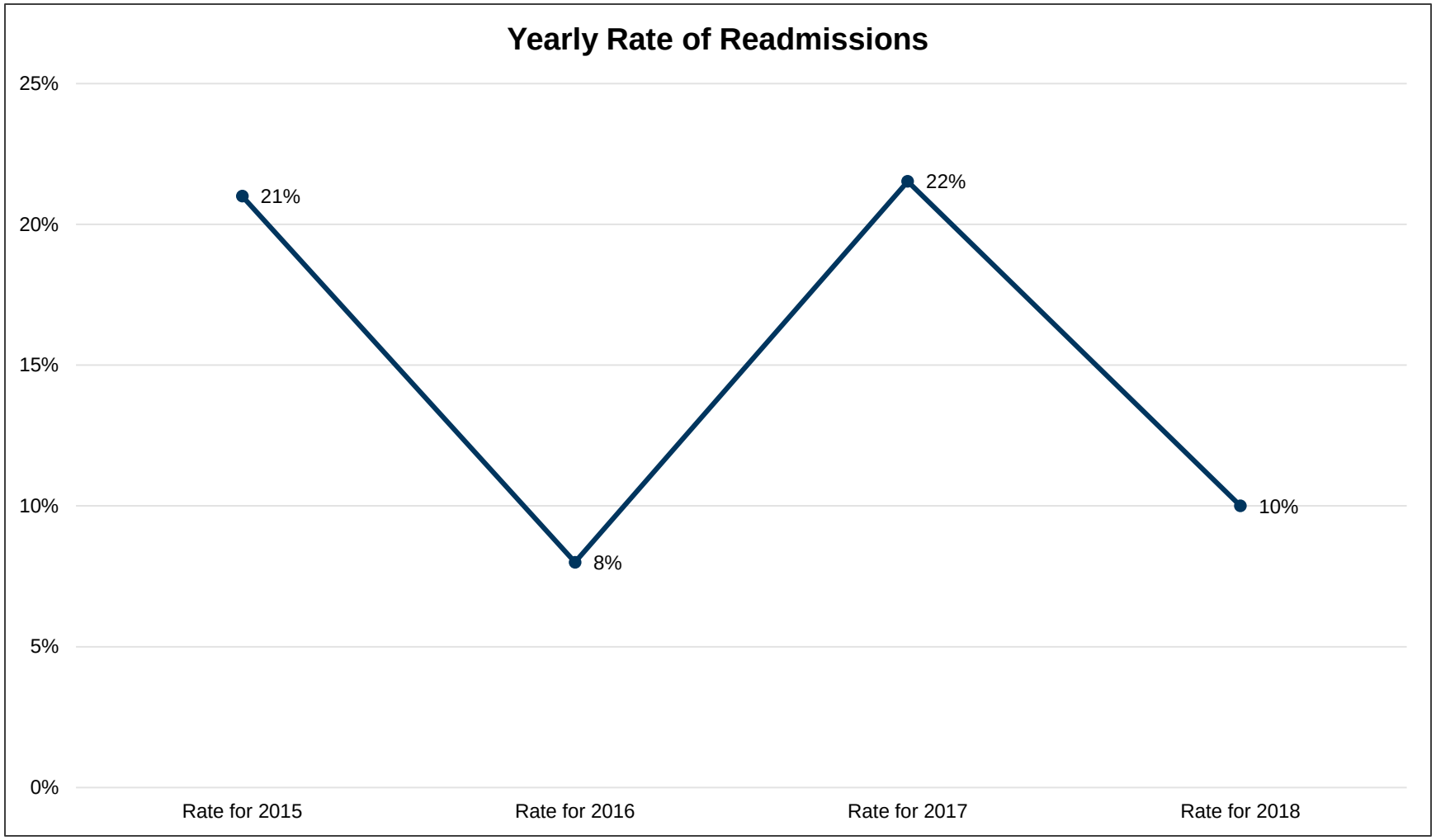
Element 20: 30-Day All-Cause Readmissions (Goal <10%)



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Element 23: Overall Satisfaction with the Care Received (Goal: 90%)

Domain	2017 CalOptima PACE	2018 CalOptima PACE	2018 CalPACE Average
Would you recommend the program to a close friend or relative?	83%	**93%**	**95%**
Overall satisfaction with the care received.	91%	**97%**	95%

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Element 23: Annual Participant Satisfaction Survey Results

Domain	2017 CalOptima PACE	2018 CalOptima PACE	2018 CalPACE Average
Transportation	98%	**93%**	93%
Center Aids	96%	**92%**	92%
Home Care	93%	**91%**	87%
Medical Care	92%	**88%**	88%
Health Care Specialist	92%	**90%**	84%
Social Worker	95%	**97%**	94%
Meal	63%	**59%**	64%
Rehabilitation Therapy and Exercise	97%	**98%**	95%
Recreational Therapy	86%	**77%**	82%
Other Indicators	94%	**92%**	89%
Weighted Score	90%	**87%**	87%

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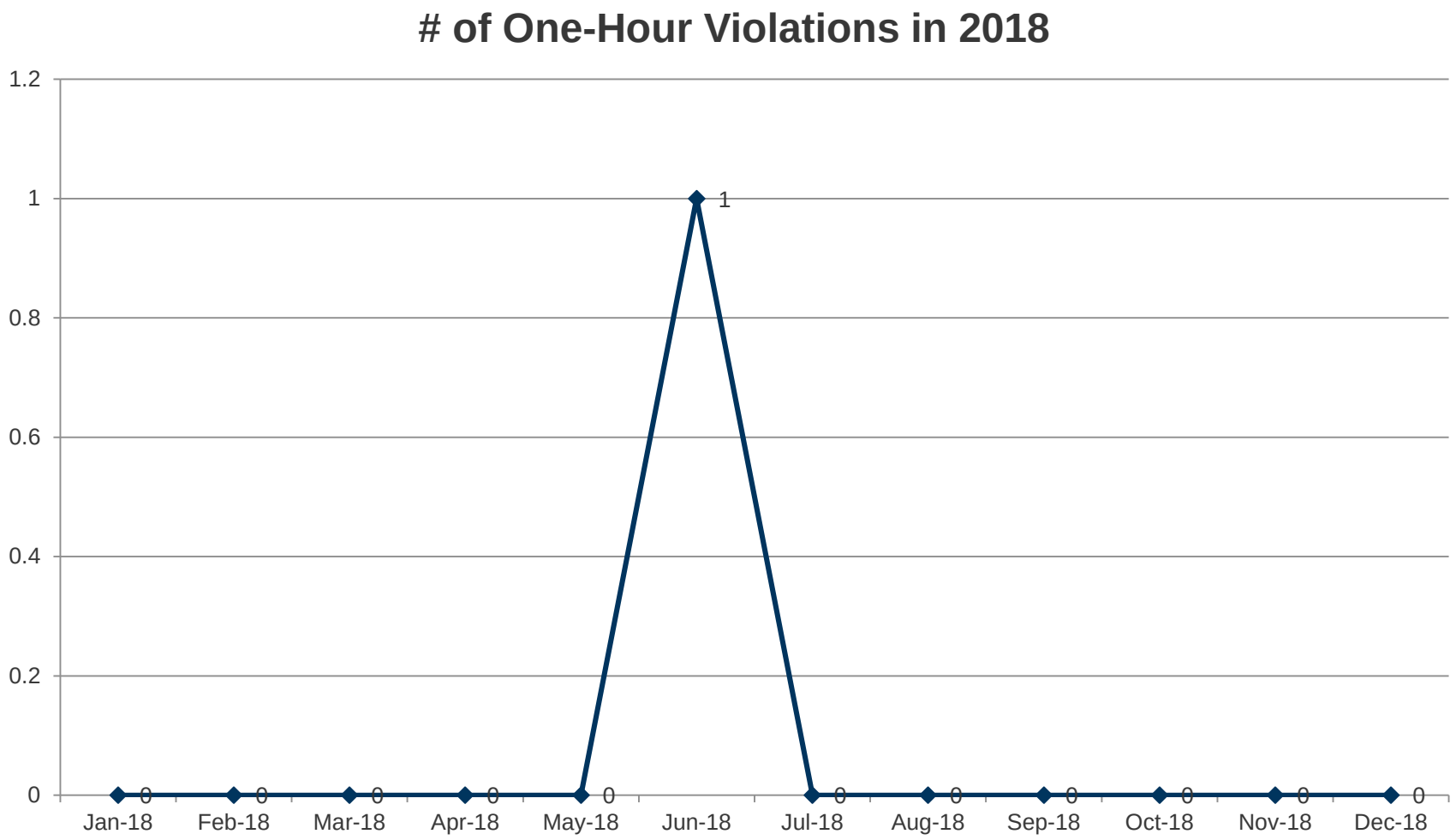
Element 24: Transportation: 1–Hour Violations (Goal: 0)



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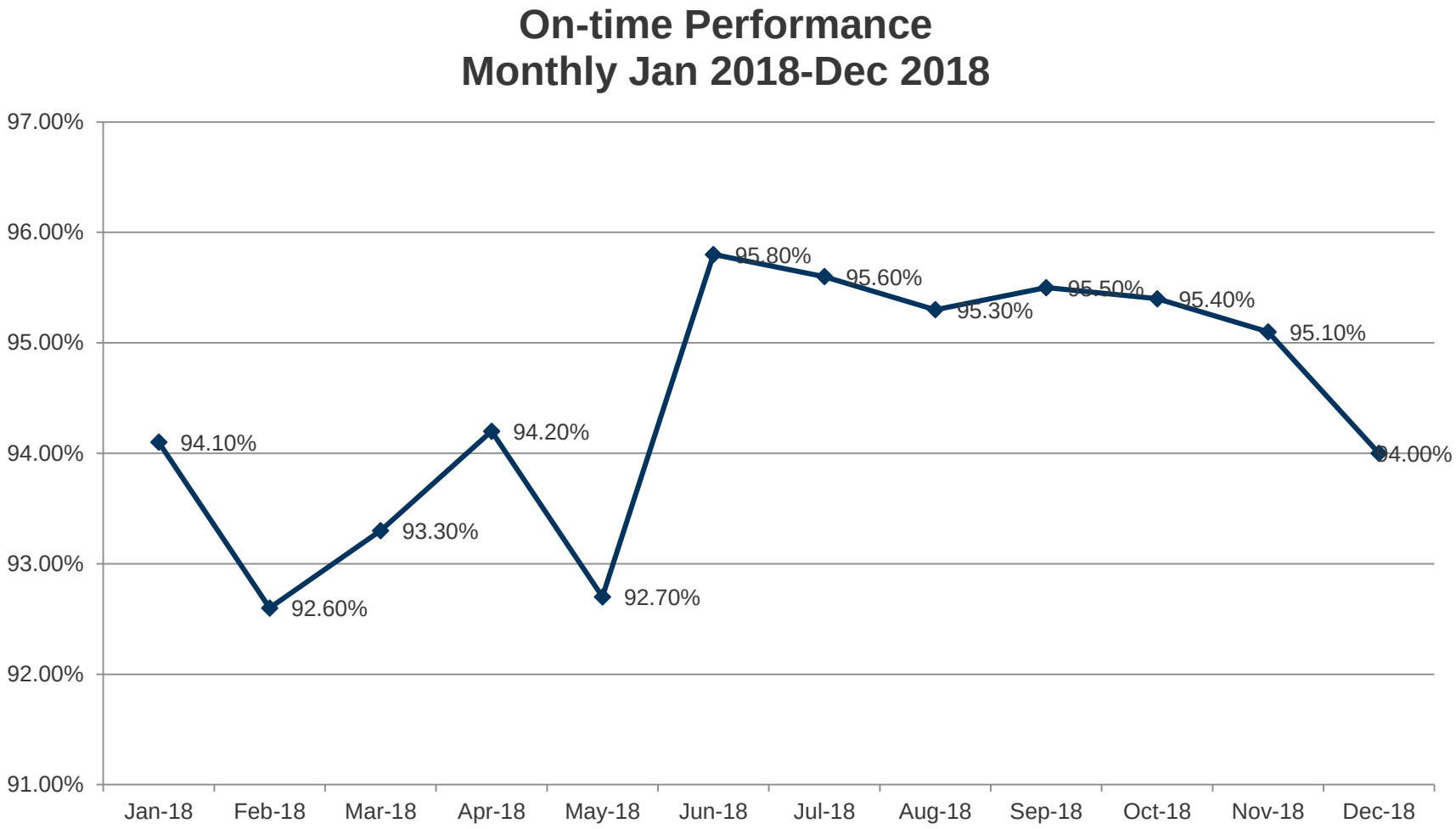
Element 25: Transportation On-Time Performance (Goal >90%)



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Opportunities for Improvement in 2019

- Quality and Safety of Clinical Care
  - Expand ACS focused QI measures
  - Implement End of Life Care Team
  - Add opioid measure
- Ensure the Appropriate Use of Resources
  - Refine ER Diversion Program
  - Improve specialty coordination
- Ensure Appropriate Access and Availability
  - Alternative Care Settings (ACS) growth
  - Expand the use of community PCPs
  - Expand of PACE at home
- Improve Participant Experience
  - Added satisfaction with meals measure

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Recommended Action

- Receive and file the 2018 PACE Quality Assessment Performance Improvement (QAPI) Plan Evaluation

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CALOPTIMA PACE

2018 CALOPTIMA PACE QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) PLAN ANNUAL EVALUATION

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SIGNATURE PAGE

Quality Improvement Subcommittee Chairperson:

_____ _____

David Ramirez, M.D. **Date:**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson

_____ _____

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

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2018 CalOptima PACE Quality Assurance Performance Improvement (QAPI) Plan Annual Evaluation

I. EXECUTIVE SUMMARY

CalOptima PACE opened for operations on October 1st, 2013. We have seen steady growth over the years with 13 members at the end of 2013, 236 members at the end of 2017 and 299 members at the end of 2018. Our members represent 15 different ethnicities who speak 10 different languages. Eighty percent of the PACE Participants utilize English as their second language. The purpose of the PACE Quality Assessment Improvement (QAPI) Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate all quality and process improvement activities and outcomes and reduce the potential risk to safety and health of PACE participants through ongoing risk management. This is done via data-driven assessments of the program which in turn drives continuous quality improvement for the entire PACE organization. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

The goals of the CalOptima PACE QAPI Plan is to improve future performance through effective Improvement activities, driven by identifying key objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff. The 2018 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2019 PACE QAPI plan.

II. PROGRAM STRUCTURE

The CalOptima's PACE QAPI Plan is developed by the PACE Quality Improvement Committee (PQIC). It is then reviewed and approved by the CalOptima Board of Directors Quality Assurance Committee (QAC) and then approved by the CalOptima Board of Directors annually. The written 2018 PACE QAPI Plan was reviewed by the CalOptima Board of Directors with approval on March 1st, 2018.

The CalOptima PACE Medical Director has oversight and responsibility for implementation of the PACE QAPI Plan. The PACE QI Manager will ensure timely collection and completeness of data with the support of the PACE QI Coordinator. Overall oversight of the PACE QAPI Plan is provided by the CalOptima Board of Directors.

The CalOptima PACE QAPI Plan incorporates continuous Quality Improvement (QI) methodology that focuses on the specific needs of Cal Optima's PACE members.

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It will foster the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- It is focused on Quality Improvement (QI) activities carried out on an ongoing basis to ensure that quality of care issues are identified and corrected.

III. PACE QAPI PROGRAM: MAJOR ACCOMPLISHMENTS IN 2018

In 2018, CalOptima PACE accomplishments include:

1. Successful CMS/DHCS Audit.
2. Successful Department of Health Care Services (DHCS) Level of Care (LOC) Audits.
3. Program growth to 299 participants. Sixteen of these participants receive services at Alternative Care Setting (ACS) sites.
4. Solidifying partnerships with 4 ACS sites, thereby meeting our expansion goals and improving access for participants into the PACE program.
5. Met 20 out of 25 workplan goals.
6. 98% of the participants received their annual influenza vaccine.
7. 90% of the participants received the Pneumococcal vaccine.
8. Infection Control: Rate of skin and respiratory infections in the elderly were lower than national benchmarks.
9. Quality of Care Healthcare Effectiveness Data and Information Set (HEDIS) metrics:
    a. 100% of the participants had their medications reviewed at least annually.
    b. 99.5% of the participants had functional assessments completed every 6 months.
    c. 100% of the participants were screened for pain.
    d. 91.5% of the participants with diabetes completed an annual eye exam.
    e. 99% of the participants with diabetes had their blood pressure controlled.
10. Utilization:
    a. 86% of the participants were scheduled with a specialty provider within 10 days.
    b. Only two participants (less than 1%) were placed on Long-Term Care.
    c. Used in-house providers in the capacity of hospitalist and nursing home physicians.
    d. Implemented the PACE Emergency Room (ER) Diversion Program.
11. Transportation:
    a. Only one 1-hour violation in all of 2018.
    b. On-time performance in the mid-90th percentile.
12. Participant Satisfaction:
    a. Overall satisfaction with the care received at PACE: 97%, second highest in the state.
    b. Better than or equal to the CalPACE average in 8 out of 10 satisfaction survey domains.
14. 100% of staff competency assessments were completed. Year-round staff trainings covering a broad area of topics including coding, infection control, wound care, emergency responses, grievances, appeals, service delivery requests and participant rights.

IV. STRATEGIC GOALS AND OBJECTIVES OF THE 2018 PACE QAPI PROGRAM

1. The QAPI program is organized to identify and analyze significant opportunities for improvement in clinical services, care and utilization.
    a. Accomplished as evidenced by the ongoing Health Plan Management System (HPMS) and QAPI individual metric data collection and analysis.
    b. Accomplished as evidenced by the ongoing PACE QAPI activities.

2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
    a. Accomplished as evidenced by the ongoing HPMS and QAPI individual metric data collection and analysis.
    b. Accomplished as evidenced by the ongoing PACE QAPI quality improvement initiatives.
    c. Accomplished as evidenced by monitoring of member grievances and complaints, and regular review of delegated entities.
    d. Accomplished by the monthly meeting with the transportation vendor.
    e. Accomplished as evidenced by the daily morning inpatient and nursing facility clinical rounds.
    f. Accomplish by the ongoing infection control activities.
    g. Collaboration with the Compliance Department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality, security, etc.
    h. Accomplished as evidenced by the annual approval of Up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners.
    a. Accomplished as evidenced by the daily Interdisciplinary Care Team (IDT) meetings at CalOptima PACE.
    b. Accomplished as evidenced by the daily morning inpatient and nursing facility clinical rounds.
    c. Accomplished by adding the hospital and nursing home attending physicians to the IDT.
    d. Accomplished by the addition of preferred specialists who agree to participate in IDT.
    e. Accomplished by the implementation of the ER Diversion Program.
4. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population.
    a. Accomplished as evidenced by the number of grievances that have been tracked and trended.
    b. Accomplished by the 88% of specialty appointments which were scheduled within 7 business days of IDT authorization.
    c. Accomplished by the Podiatrist and Dentist coming to the PACE center to see and treat the PACE participants.
    d. Accomplished by the Podiatrist, Psychiatrist, Nephrologist and Dentist participating in the IDT meetings.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service.
    a. Accomplished as evidenced by the credentialing and peer review process.
    b. Accomplished as evidenced by annual evaluations of all CalOptima PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances.

a. Accomplished as evidenced by PACE Member/Member's Caregiver Satisfaction Survey.
b. Accomplished as evidenced by the summary of GARs activities.

7. Risk prevention and risk management processes.
    a. Accomplished as evidenced by the QI activities which occur around all Unusual Incidents.
    b. Accomplished as evidenced by Physical Therapy driven groups such as *Fall Prevention Group, Fall Committee, Fallers Anonymous and Matter of Balance*.groups.
    c. Accomplished as evidenced by Root Cause Analysis done on Level Two incidences/Unusual Quality Incidences.
8. Compliance with regulatory agencies and accreditation standards.
    a. Accomplished as evidenced by CMS/DHCS and two Level of Care Audits.
9. Compliance with Clinical Practice Guidelines and evidence-based medicine.
    a. Accomplished as evidenced by the adoption of the National PACE Association Preventative Guidelines
    b. Accomplished as evidenced by the adoption of Uptodate.com clinical practice standards.
10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently.
    a. Accomplished as evidenced by tracking, trending and analyzing UM data monthly.
    b. Accomplished by the enhancement of the provider incentive program.
    c. Accomplished by the implementation of the ER Diversion Program.
    d. Accomplished by the weekly PACE management team meetings.
    e. Accomplished by the participation in the CalOptima Quality Improvement, Utilization Management, and Credentialing and Peer Review Committee meetings.
    f. Accomplished by the participation in the CalOptima Board of Directors and the Board of Directors Quality Improvement committee meetings.

V. SUMMARY OF ACCOMPLISHMENTS, BARRIERS AND ACTIONS

2018 QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT WORK PLAN - ELEMENTS BY CATEGORY:

Quality of Care

QAPI18.01 PACE QAPI Plan and Work Plan will be evaluated annually

Received and filed by the CalOptima Board of Directors on February 7, 2019.

QAPI18.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Board of Directors on February 7, 2019.

QAPI18.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: >90%

Goal: Met

Data/Analysis: 98% of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

Continue metric in 2019 work plan for oversight of HPMS required monitoring. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

1. Negative media communication regarding the efficacy of the Influenza vaccine in previous years influenced participant's refusal of the vaccine.
2. Opportunities for Improvement
    a. Education: Beginning September 2019 through March 2020, PACE nursing staff will provide monthly influenza vaccine education for participants as part of Day Floor activities. Medical providers will enhance education opportunities during participant's medical visits.
    b. Utilize EMR's quality analytics for tracking of missed opportunities for immunization.
    c. QI will give immunization reports bimonthly during the months of October – March.
    d. Follow-up with all participants who refused influenza immunization monthly during the months of October – March.

QAPI18.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: >90%

Goal: Met

Data/Analysis: 90% of participants received the Pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement: We will continue this metric in the 2019 Work Plan for oversight of HPMS required monitoring. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

One of the main barriers in vaccinating our participant population is the difficulty in obtaining previous medical records with prior vaccination documentation for new participants. Looking forward into 2019, we plan to implement the following to assure greater vaccination rates:

a. Implement guidelines and workflows for Standing Orders and Standardized Procedures in vaccine administration.

b. Utilize EMR's quality analytics for tracking of missed opportunities for immunization.

c. Clinic staff to work with QI staff to develop a new report detailing "missed opportunities" which will be distributed monthly.

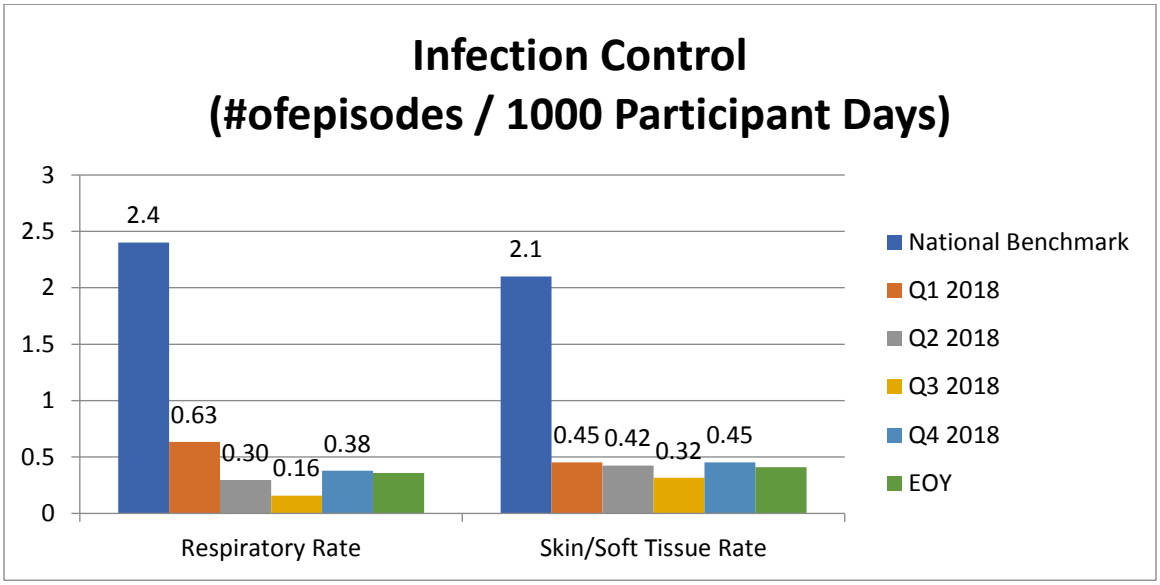
d. Annual Wellness Exams: This will be accomplished by the addition of one part time Nurse Practitioner who will be dedicated to ordering all preventive screenings (i.e. immunizations, disease related laboratory tests) and tracking test and screening results. The Nurse Practitioner will also be involved in chronic disease management and provide recommendations for Care Plan interventions.

QAPI18.05 Reduce common infectious in PACE participants (Respiratory and Skin)

Goal: Maintain common infection rates less than the following national benchmarks: Respiratory Tract 0.1-2.4 episodes/1000 participant days. Skin and Soft Tissue

Goal: Met

Data/Analysis: See Graphs Below:



Summary and Key Findings/Opportunities for Improvement: Overall, rates were consistently below benchmarks.

In 2018 we focused heavily on infection control. We began our influenza vaccination program as soon as the vaccine was released. This assured a high number of vaccinated individuals thereby reducing potential influenza outbreaks among our participants. In addition, if participants displayed any symptoms of flu-like symptoms, they were promptly separated from others and were sent home with "PACE at Home" services. Also new in 2018 is our newly contracted after-hours service which was able to respond to calls by using either a physician or a registered nurse. This led to an immediate triage and interventions, often averting serious consequences. We also employed an aggressive education program for the participants as well as the staff. Staff were offered the influenza vaccine on-site and infection control measures such as handwashing, respiratory hygiene/cough etiquette, droplet precautions, were implemented. Comprehensive diabetic skin care with regular wound care greatly diminished skin and soft tissue infections. All measures greatly reduced potential infectious outbreaks.

QAPI18.06 Increase POLST utilization for PACE participants

Goal: 75% of members who have been enrolled in the PACE program for 6 months will have a POLST completed.

Goal: Met

Data/Analysis: 100% participants had PLOST by the end of 2018.

Quarter 2018	Completion Rate
Q1	100%
Q2	100%
Q3	100%
Q4	100%

Summary and Key Findings/Opportunities for Improvement: At the end of 2018, 100% of PACE participants had a completed POLST on file. This had been one of the program's key initiative to ensure that we understood and delivered the end-of-life care which is consistent with the participants wishes. We experienced some challenges with implementing the POLST document when it came to end-of-life decisions. This opened new discussions among our Leadership Team and ended with and End-Of-Life Group led by our palliative care physician. Current discussions revolve around encouragement of family members to participate in end-of-life discussions which previously was met with reluctance on the part of family members. We are addressing the designation of one family member who will act as the "voice of the family" when end-of-life discussions become imminent. Social Workers, the PCP as well as the RN and integral parts of this discussion.

QAPI18.07 Care for Older Adults: Medication Review (COA)

Goal: 100%

Goal: Met

Data/Analysis: Met Goal with 100% achievement

Medication Review	Q1 2018	Q2 2018	Q3 2018	Q4 2018
Charts with Med Review	251	269	286	299
Census at End of Quarter	251	269	286	299
Rate	100%	100%	100%	100%

Care for Older Adults: Medication Review					
		2018 Star Rating Measure Cut Points			
MY 2018 PACE	MY 2017 OCC	2 Stars	3 Stars	4 Stars	5 Stars
100%	29.66%	59% to 79%	79% to 88%	88% to 93%	≥ 93%

Summary and Key Findings/Opportunities for Improvement:

The PCP and the in-house pharmacist perform a medication review on an annual basis. The PACE QI Team performs a review of the EMR Medication Management Forms to validate adherence. Because we achieved 100% adherence for last two years, we will consider sun-setting this element in 2019.

QAPI18.08 Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS

Goal: 100%

Goal: Met

Data/Analysis: In Q3 we had one comatose participant and as such, presented a challenge for disciplines to conduct a functional status assessment. Eventually, the disciplines did see the participant in the hospital and were able to conduct the assessment, however it was not completed within the 6-month timeframe. CMS agreed that this participant should be excluded from the 6-month functional status assessment as the assessment could not be done during the assessment period. We did not remove those 6 assessments from our data.

Functional Status Assessment	Q1 2018	Q2 2018	Q3 2018	Q4 2018	EOY
Charts with All Assessments	251	269	280	299	1099
Census at End of Quarter	251	269	286	299	1105
Rate	100%	100%	98%	100%	99.5%

Care for Older Adults: Functional Status Assessment					
		2018 Star Rating Measure Cut Points			
MY 2018 PACE	MY 2017 OCC	2 Stars	3 Stars	4 Stars	5 Stars
99.5%	28.69%	46% to 67%	67% to 78%	78% to 92%	≥ 92%

Summary and Key Findings/Opportunities for Improvement:

Although we have an excellent compliance rate, we still have limited reporting functionality in current EMR which impedes efficient identification of participants requiring assessments/reassessments. To assure continued compliance, we will continue to have PACE QI Team provide monthly reports to IDT with assessment due dates. The Center Manager will assure timely completion of assessments prior to care planning. This result is comparable to a 5-Star Medicare Rating.

QAPI18.09 Care for Older Adults: Pain Screening (COA)

Goal: 100%

Goal: Met

Data/Analysis: Met Goal at 100% achievement.

Pain Screening Assessment	Q1 2018	Q2 2018	Q3 2018	Q4 2018
Charts with Pain Screening	251	269	286	299
Census at End of Quarter	251	269	286	299
Rate	100%	100%	100%	100%

Care for Older Adults: Pain Screening					
		2018 Star Rating Measure Cut Points			
MY 2018 PACE	MY 2017 OCC	2 Stars	3 Stars	4 Stars	5 Stars
100%	30.48%	40% to 62%	62% to 80%	80% to 94%	≥ 94%

Summary and Key Findings/Opportunities for Improvement: The 100% achievement in conducting Pain Screening for our participants is equivalent to a 5-star Medicare rating. In 2019 we expect to continue to exceed the benchmarks due to enhanced resources and care coordination activities. Due to meeting this benchmark with 100% compliance for the last few years, we will consider sun-setting this element in 2019. This result is comparable to a 5-Star Medicare Rating.

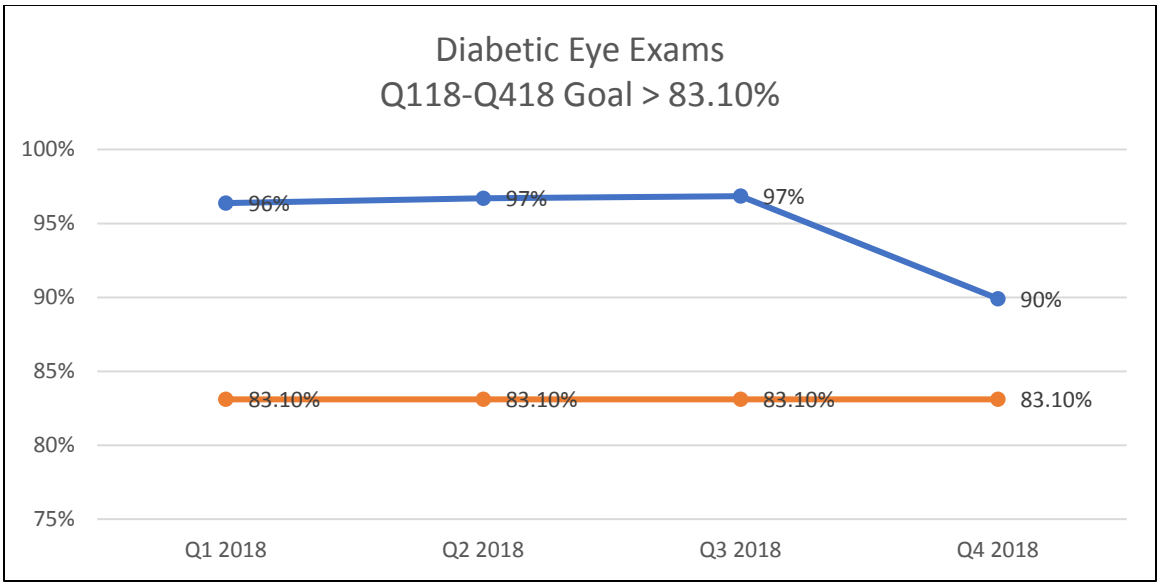
QAPI18.10 Increase the percentage of PACE participants with diabetes who get their annual diabetic eye exam completed

Goal: > 83.10% (MEDICARE Quality Compass - 2016 HEDIS 90th percentile)

Goal: Met

Data/Analysis: See Graphs Below:

Quarter 2018	Completion Rate
Q1	96%
Q2	97%
Q3	97%
Q4	90%



Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
		Quality Compass 2017 HEDIS Percentiles			
MY 2018 PACE	MY 2017 OCC	25th Percentile	50th Percentile	75th Percentile	90th Percentile
90%	67.18%	63.02%	70.91%	78.41%	83.54%

Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
		2018 Star Rating Measure Cut Points			
MY 2018 PACE	MY 2017 OCC	2 Stars	3 Stars	4 Stars	5 Stars
90%	67.18%	47% to 59%	59% to 72%	72% to 81%	≥ 81%

Summary and Key Findings/Opportunities for Improvement:

Met target goal of > 83.10% of participants receiving an annual diabetic eye exam per Medicare Quality Compass. In analyzing the data, it was found that some participants were listed as needing eye exams and upon closer inspection, were deemed inappropriate due to factors such as cognitive impairment. Looking ahead to 2019, we anticipate the purchase of optometry equipment and contracting with an optometrist who can provide in-house eye exams. Annual Wellness Visits which are focused on preventative screenings and chronic disease monitoring will aide in meeting our goal. This result is comparable to a 5-Star Medicare Rating and is in the 90th Quality Compass 2017 HEDIS Medicare/Medi-Cal percentile.

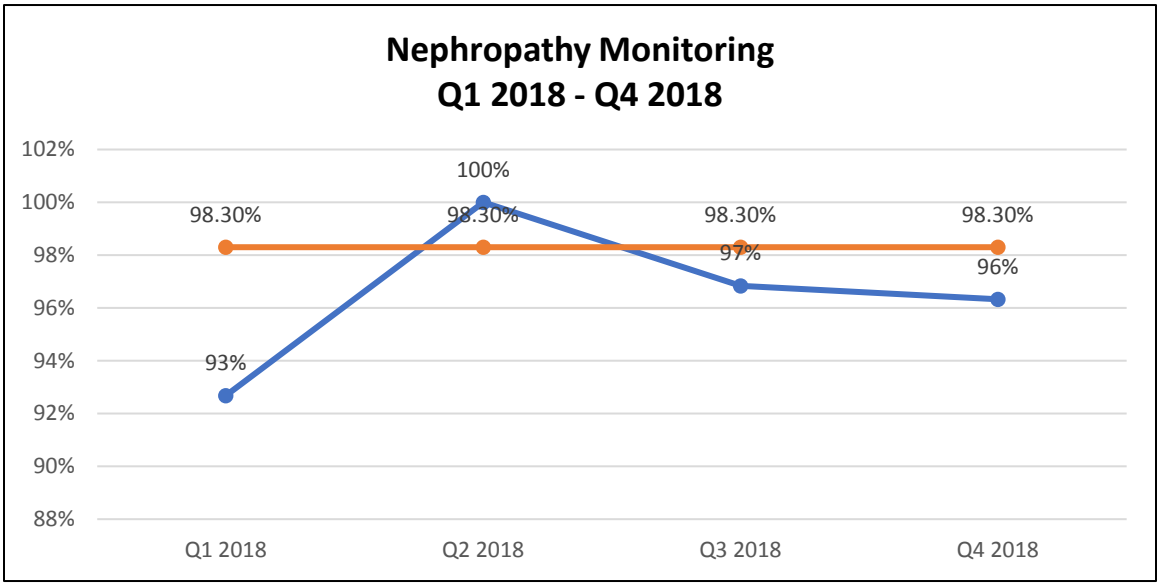
QAPI18.11 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: >98.30% (MEDICARE Quality Compass - 2016 HEDIS 90th percentile)

Goal: Not Met

Data/Analysis: In Quarters 1, 3, and 4 we did not meet our goal, although we maintained in the 90th percentile.

Quarter 2018	Completion Rate
Q1	93%
Q2	100%
Q3	97%
Q4	96%



Comprehensive Diabetes Care: Nephrology Monitoring					
		Quality Compass 2017 HEDIS Percentiles			
MY 2018 PACE	MY 2017 OCC	25th Percentile	50th Percentile	75th Percentile	90th Percentile
96%	94.54%	94.16%	95.86%	97.48%	98.88%

Comprehensive Diabetes Care: Nephrology Monitoring					
		2018 Star Rating Measure Cut Points			
MY 2018 PACE	MY 2017 OCC	2 Stars	3 Stars	4 Stars	5 Stars
96%	94.54%	92% to 94%	94% to 96%	96% to 98%	≥ 98%

Summary Key Findings/Opportunities for Improvement: A common element in not achieving our intended goal was the lack of orders for nephropathy screening (11 participants were identified). To correct this, we will implement Standing Orders for nephropathy screening which will be ordered during the Annual Wellness Visits performed by a Nurse Practitioner. These visits will begin in 2019. This result is comparable to a 4-Star Medicare Rating and is in the 90th Quality Compass 2017 HEDIS Medicare/Medi-Cal percentile.

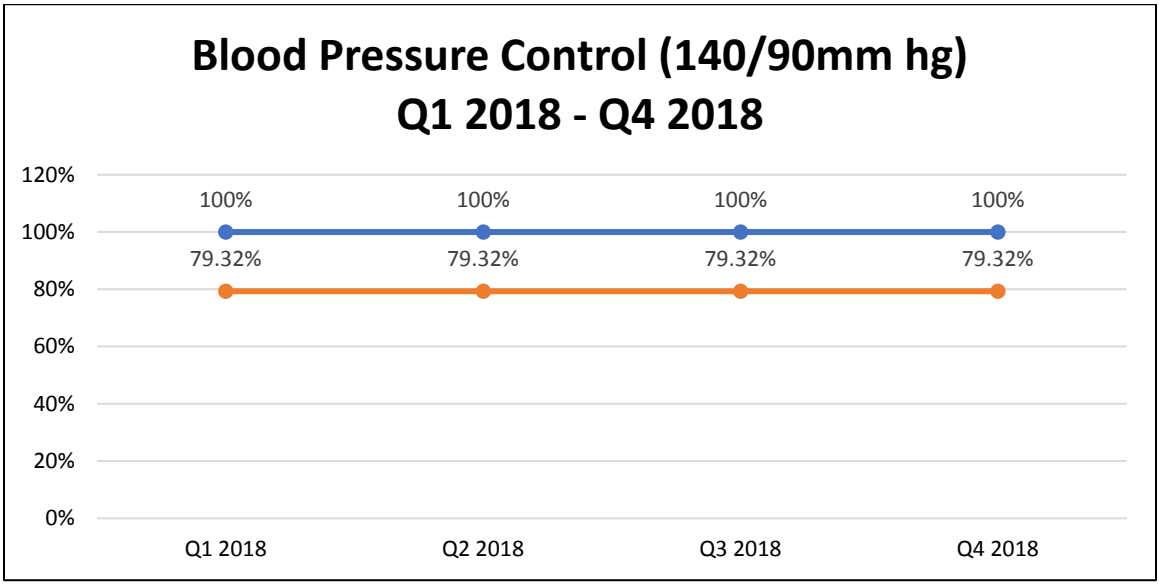
QAPI18.12 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: >79.32% (MEDICARE Quality Compass - 2016 HEDIS 90th percentile)

Goal: Met

Data/Analysis: See graph below:

Quarter 2018	Completion Rate
Q1	100%
Q2	100%
Q3	100%
Q4	100%



Comprehensive Diabetes Care: Blood Pressure Control					
		Quality Compass 2017 HEDIS Percentiles			
MY 2018 PACE	MY 2017 OCC	25th Percentile	50th Percentile	75th Percentile	90th Percentile
100%	32.75%	57.87%	65.82%	73.72%	80.12%

Comprehensive Diabetes Care: Blood Pressure Control					
		2018 Star Rating Measure Cut Points			
MY 2018 PACE	MY 2017 OCC	2 Stars	3 Stars	4 Stars	5 Stars
100%	32.75%	40% to 64%	64% to 73%	73% to 80%	≥ 80%

Summary and Key Findings/Opportunities for Improvement:

We exceeded our goals in this element due to the prompt identification of participants with poor control of their blood pressure. These identified participants are monitored on every attendance day, with out-of-range numbers leading to direct intervention. The interventions include in-house pharmacist consults as well as adjustments in medication by the medical provider. This result is comparable to a 5-Star Medicare Rating and is in the 90th Quality Compass 2017 HEDIS Medicare/Medi-Cal percentile.

QAPI18.13 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus Tricyclic Antidepressants or Antipsychotics

Goal: <38.91% (Quality Compass - 2016 HEDIS 90th percentile)

Goal: Not Met

Data/Analysis: End of Year rate is 48% (78 out of 161 participants)

Falls	Q1	Q2	Q3	Q4	EOY
#of Drug + Disease Combinations	9	23	17	29	78
#of Participants with dx	47	43	39	32	161
Rate	19%	53%	44%	91%	48%

DDE: Falls plus Tricyclic Antidepressants or Antipsychotics					
		Quality Compass 2017 HEDIS Percentiles			
MY 2018 PACE	MY 2017 OCC	25th Percentile	50th Percentile	75th Percentile	90th Percentile
48%	42.43%	52.52%	46.88%	42.70%	37.25%

Summary and Key Findings/Opportunities for Improvement:

This was the first year for this element and the goals were found not to be appropriate. The goals are based on a healthy Medicare population as opposed to a nursing home eligible Medicare population. For the upcoming year, we will be eliminating this element and replacing it will a measure specific to decreasing falls in the day centers. In addition to being a better process improving element, it will also allow us to ensure the quality of care across the Alternative Care Setting (ACS) sites as we continue to expand. We will continue with our "Falls Prevention"

efforts by providing group classes (*Fallers Anonymous, Fall Committee, Matter of Balance*). Finally, we are planning on bringing Psychiatry in-house via telemedicine which will allow for improvement in communication and coordination. The Psychiatrists will attend the IDT meetings.

QAPI18.14 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <37.50% (Quality Compass - 2016 HEDIS 90th percentile)

Goal: Met

Data/Analysis: End of Year rate is 24% (23 out of 96 participants)

DDE: Dementia + tricyclic antidepressant or anticholinergic agents					
		Quality Compass 2017 HEDIS Percentiles			
MY 2018 PACE	MY 2017 OCC	25th Percentile	50th Percentile	75th Percentile	90th Percentile
24%	48.05%	50.78%	45.37%	40.61%	36.13%

Summary and Key Findings/Opportunities for Improvement:

This result is comparable to the 90th Quality Compass 2017 HEDIS Medicare/Medi-Cal percentile. We anticipate an improvement in 2019 due to our intention to bring Psychiatry in-house in 2019. In addition, potential harmful drug/disease interaction within our frail and elderly population will be a focus of our pharmacist when she completes the comprehensive medication reviews.

QAPI18.15 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs

Goal: <3.70% (Quality Compass - 2016 HEDIS 90th percentile)

Goal: Not Met

Data/Analysis: End of Year rate is 1% (1 out of 36 participants)

DDE: CKD+ Nonaspirin NSAIDS or Cox2 Selective NSAIDs					
		Quality Compass 2017 HEDIS Percentiles			
MY 2018 PACE	MY 2017 OCC	25th Percentile	50th Percentile	75th Percentile	90th Percentile
24%	25.24%	<14.36%	<9.40%	<6.38%	<3.85%

Summary and Key Findings/Opportunities for Improvement:

As of the end of 2019, no participant with CKD is on NSAIDs or Cox2 Selective NSAIDs. The coordinated efforts of the Annual Wellness Nurse Practitioner and the PACE pharmacist will assure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease.

QAPI18.16 Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge

Goal: >90%

Goal: Met

Data/Analysis: 95% of the participants had medications reconciled within 30 days post discharge

Medication Reconciliation Post-Discharge	Q1 2018	Q2 2018	Q3 2018	Q4 2018	EOY
Total # of Discharges	47	28	35	22	132
Received Reconciliation	45	27	32	21	125
Rate	96%	96%	91%	95%	95%
Goal	90%	90%	90%	90%	90%

Medication Reconciliation Post-Discharge					
		Quality Compass 2017 HEDIS Percentiles			
MY 2018 PACE	MY 2017 OCC	25th Percentile	50th Percentile	75th Percentile	90th Percentile
95%	5.57%	28.30%	45.79%	61.31%	74.21%

Medication Reconciliation Post-Discharge					
		2018 Star Rating Measure Cut Points			
MY 2018 PACE	MY 2017 OCC	2 Stars	3 Stars	4 Stars	5 Stars
95%	5.57%	19% to 37%	37% to 55%	55% to 68%	≥ 68%

Summary and Key Findings/Opportunities for Improvement:

Prompt medication reconciliation post hospital discharge remains to be another one of our strong points. In 2018, we contracted with House Calls Medical Associates which serves as our after-hours call center. Additionally, House Calls Medical Associates provides our hospitalists as well as our nursing home physician. This partnership has greatly aided in our timely reconciliation process since the physician staff is familiar with the medical needs of our participants. 5-STAR Medicare and HEDIS Quality Compass in 90th percentile met.

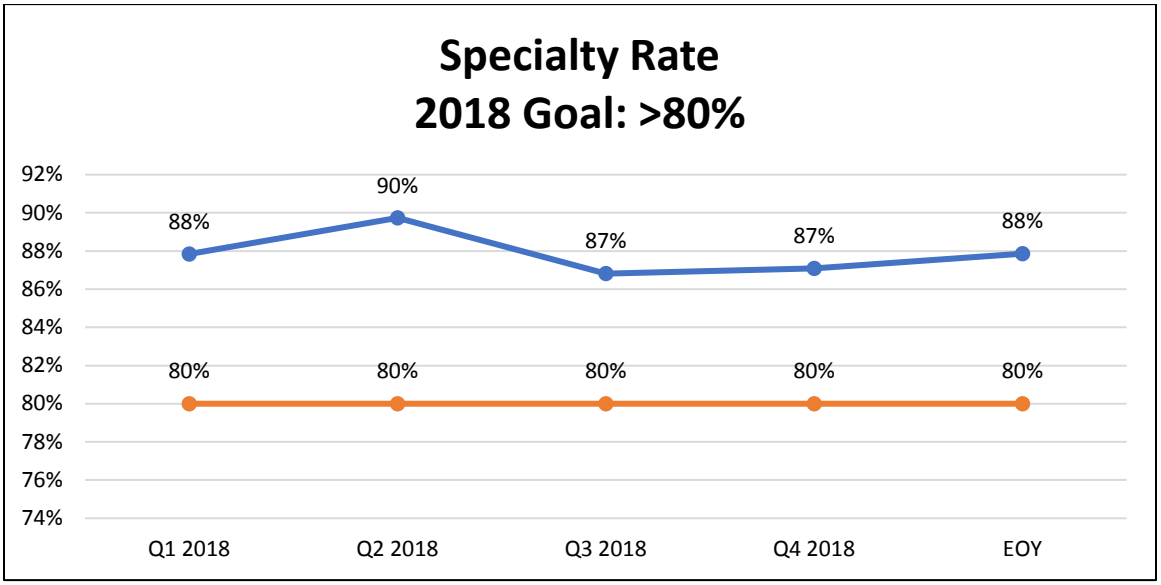
Access and Availability

QAPI18.17 Improve access to specialty practitioners

Goal: > 80% of specialty care authorizations will be scheduled within 10 days

Goal: Met

Data/Analysis: 1257/1457 (86%)



Summary and Key Findings/Opportunities for Improvement:

Over the past years, we have concentrated efforts on scheduling specialty care authorized visits in a timely manner. This has been accomplished through a variety of methods:

1. Addition of two scheduling staff members. Not only do they schedule appointments and coordinate transportation needs, they also remind participants, coordinate with participant's family, provide interpreters or escorts (if needed), send relevant medical records to the authorized specialist and follow-up on specialty consult notes.
2. Contracting additional specialists, thereby enlarging our specialty pool and permitting timely access
3. Bringing specialist in-house (podiatry, dental, and soon, optometry and psychiatry).

We will continue to monitor this element as we start to get more participants in the northern and southern parts of the county.

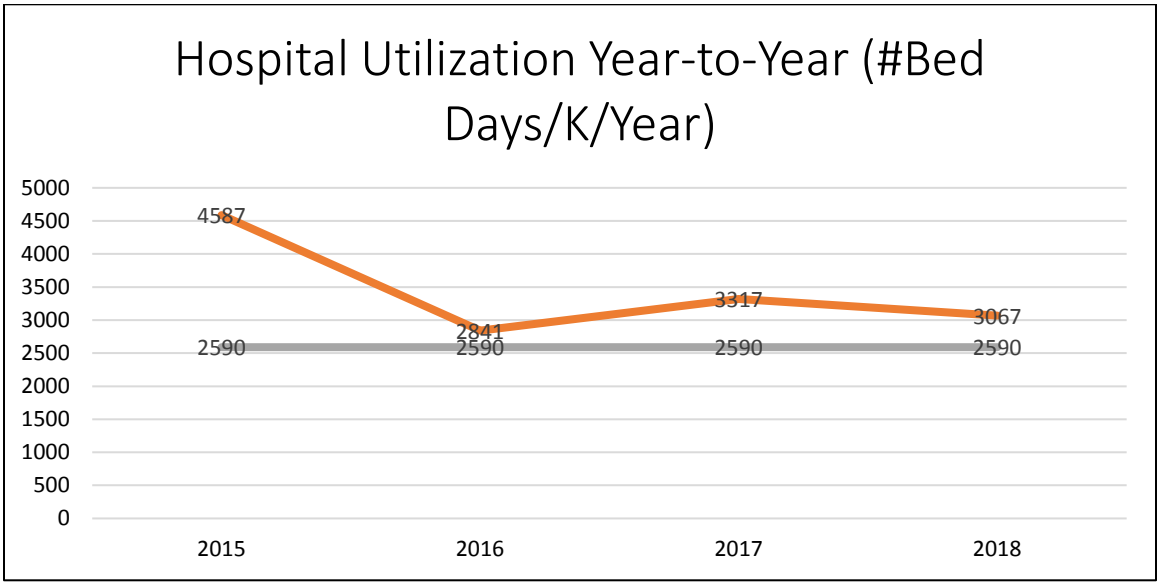
Utilization Management

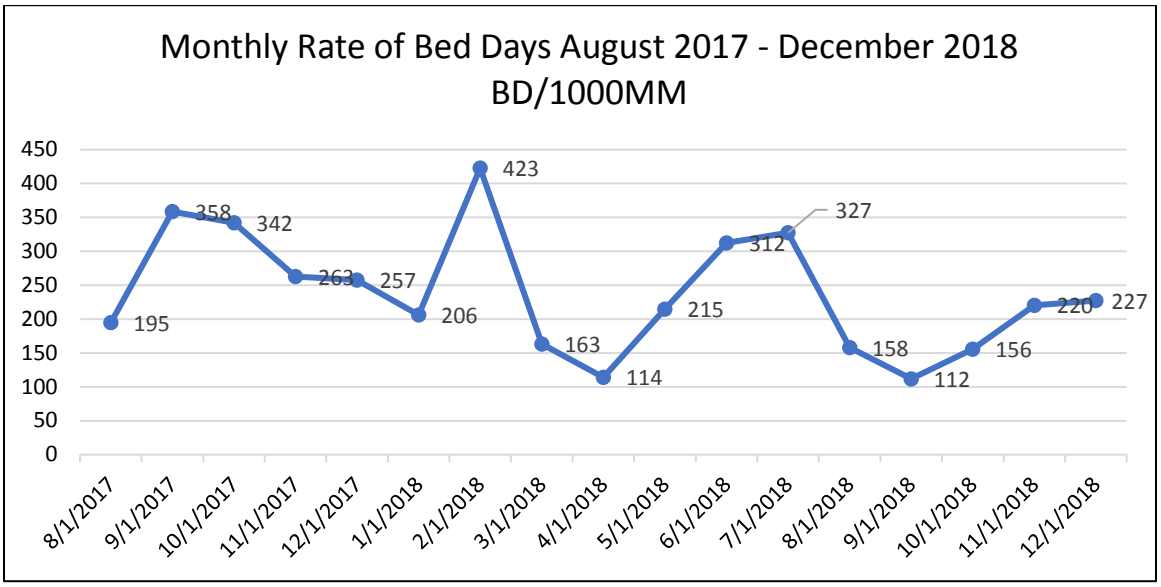
QAPI18.18 Reduce the rate of acute hospital days by PACE participants

Goal: < 2,590 hospital days per 1000 per year (CalPACE avg in 2015)

Goal: Not Met

Data/Analysis: Bed days trended lower year over year. Significant improvements were seen starting in July 2018 which corresponded with the implementation of the ER Diversion Program. The small number of participants often lead to wide variations in the acute inpatient bed day rates.





Summary/Key Findings/Opportunities for Improvement:

We found that once PACE participants went to the ER, the ER physician often admitted these participants due to the participant's fragility and the ER physician's unfamiliarity with the PACE program. Therefore, we implemented an ER Diversion Program that went live in the middle of July 2018. This program has given our after-hours on-call physicians with added options. In addition to doing a phone triage, they can send a provider to the members home to evaluate the member in real time, they can divert them to a nursing facility or meet them in the ER. As a result of this program, we saw the hospital bed day rate drop in the second half of the year.

We also found that most of the visits came from a small subset of participants. One of these subsets were participants on dialysis who were often sent directly to the ER from the dialysis center, often for minor issues. We have begun to work more closely with two specific nephrologists to help remedy this situation. Additionally, in 2019, we are adding an additional staff member whose will focus part of their time providing enhanced case management to some of these participants.

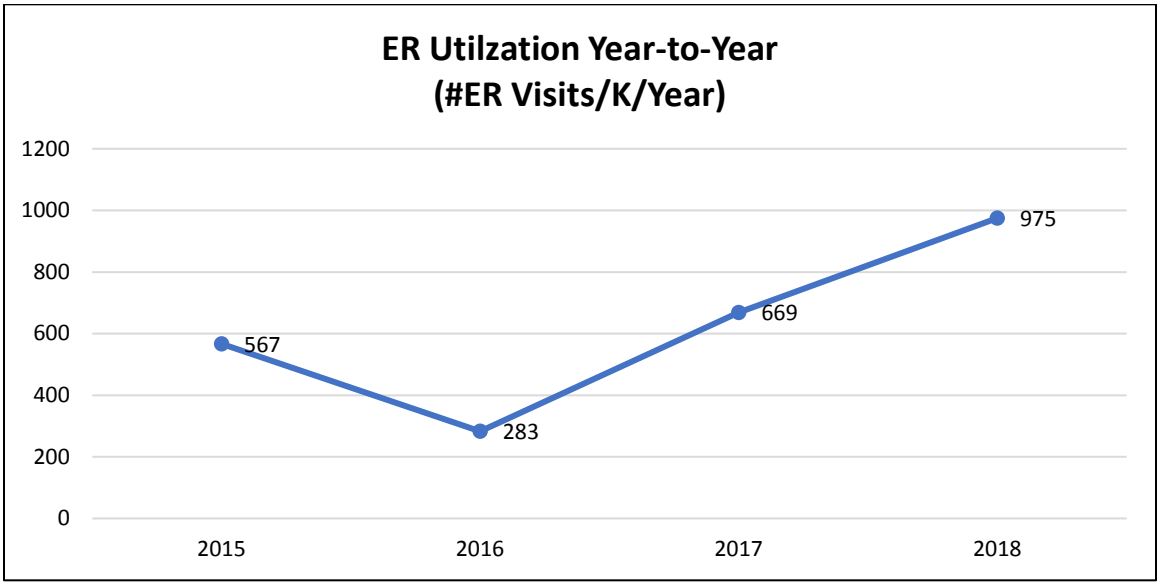
Finally, we have started to meet monthly with the after-hours on-call providers and inpatient physicians to ensure appropriate levels of communication.

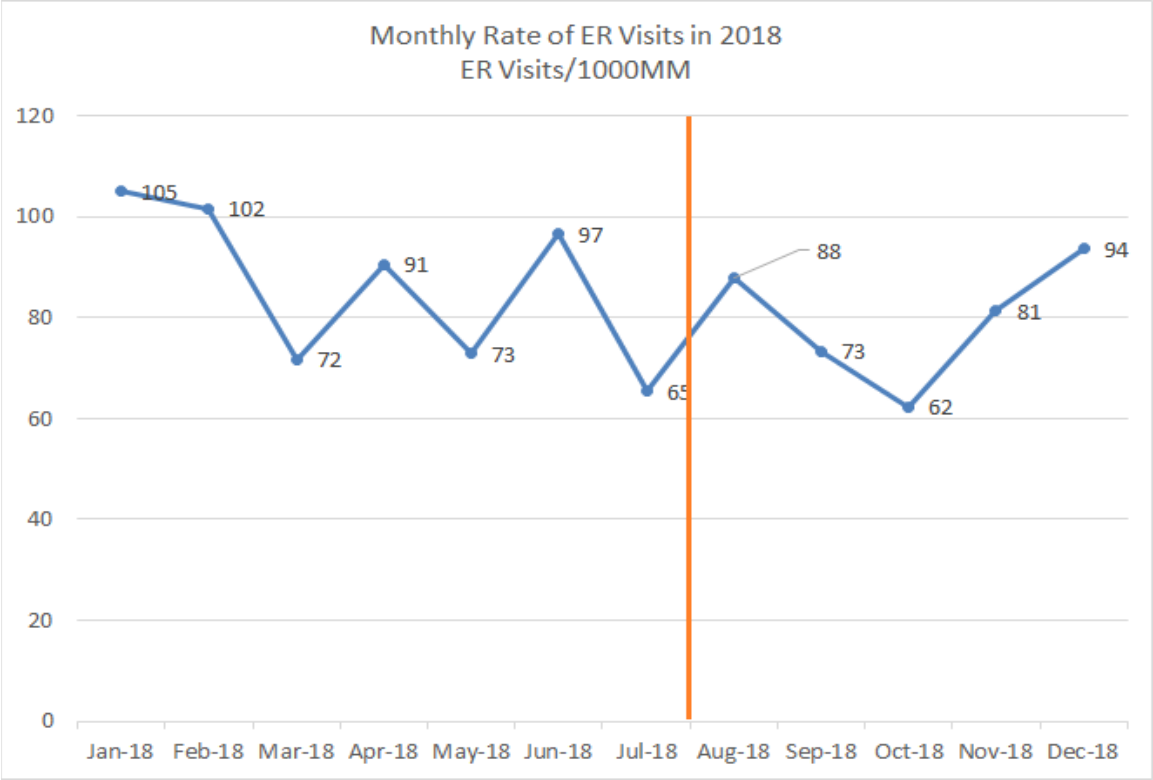
QAPI18.19 Reduce the rate of ER utilization by PACE participants

Goal: < 458 emergency room visits per 1000 per year (CalPACE avg in 2015)

Goal: Not Met

Data/Analysis: The 2018 final rate was 975 emergency room only visits per 1000 per year. The CalPACE average rates also increased to 656 ER visits per 1000 per year in 2018.





Summary and Key Findings/Opportunities for Improvement:

Our overall ER rate has increased over the last few years. As with the previous element of Hospital Utilization – QAPI18.18, we are anticipating our ER utilization to decrease due to our recently implemented ER Diversion Program. Through this program, our after-hours on-call physicians can employ triage strategies (i.e. send a RN to the participant home, divert to a nursing facility) and eliminate the need for an ER visit. We have seen the ER rate fall slightly since its implementation. Even when the participants are going to the ER, our after-hours physicians are often meeting them there which has decreased the overall rate of admissions. As with the previous measure, we will be focusing enhanced case management on our frequent ER utilizers as well as with the vendors who are frequently sending our members to the ER.

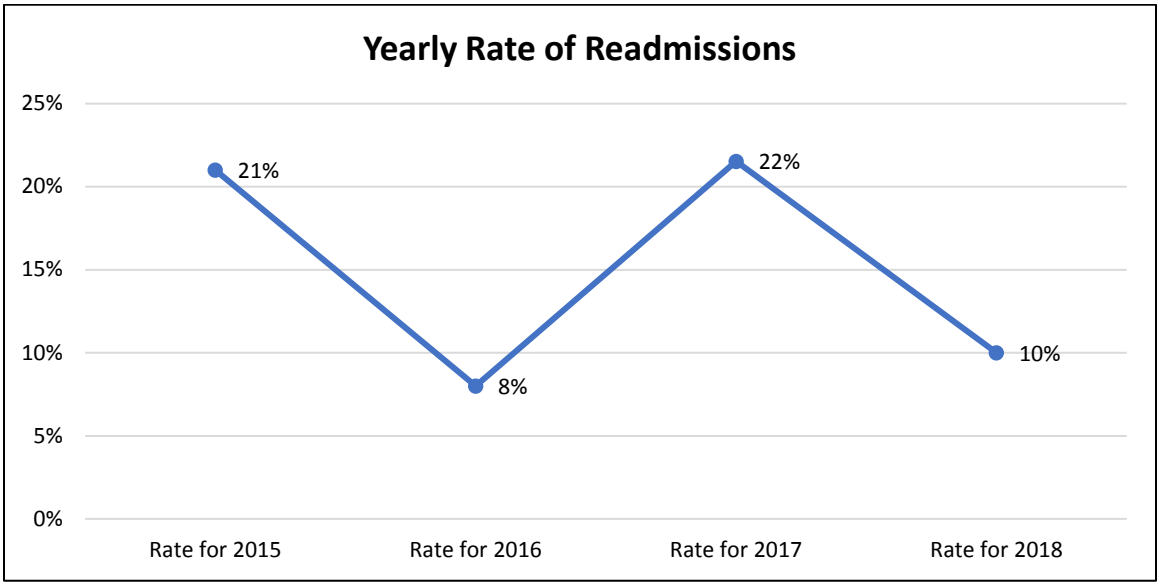
QAPI18.20 Reduce the 30-day all cause readmission rates by PACE participants

Goal: </=10% 30-day all cause readmission (CalOptima PACE avg in 2018 is 15%)

Goal: Met

Data/Analysis: See Graphs Below:

Year	# of Readmission
2015	N/A
2016	8
2017	31
2018	15



Summary and Key Findings/Opportunities for Improvement:

We ended 2018 with a 10% 30-day readmission rate by PACE participants. This number dropped substantially (12 percentage points) from the previous year, although we do see wide fluctuations year over year due to the small PACE participant population. In 2018, we implemented a case-management program which actively follows participants from inpatient hospitalization to discharge. Part of this workflow entails making a follow-up hospital visit within 2 days of discharge. These visits have been particularly effective. In 2019, we will implement an enhanced case-management program where we will monitor our more complex participants.

QAPI18.21 Decrease the percentage of participants who are placed in a long-term care facility

Goal: <4% of members (CalPACE average in 2016) will reside in long term care

Goal: Met

Data/Analysis: We had two participants who were in Long-Term Care in 2018, which is less than 1% of the PACE enrollment

Summary and Key Findings/Opportunities for Improvement:

This is one of our key elements as the goal of PACE is to help nursing home eligible participants to live safety at home as long as possible. Although the number of participants residing in long-term care facilities in less than 1%, we recognize that as our program matures, we will see an increase in the percentage of participants who are placed in a long-term care facility. We also recognize that we need more facilities for respite care as well as custodial services. This past year (2018), we integrated a nursing facility physician into our Care Team, and this has enhanced care continuity.

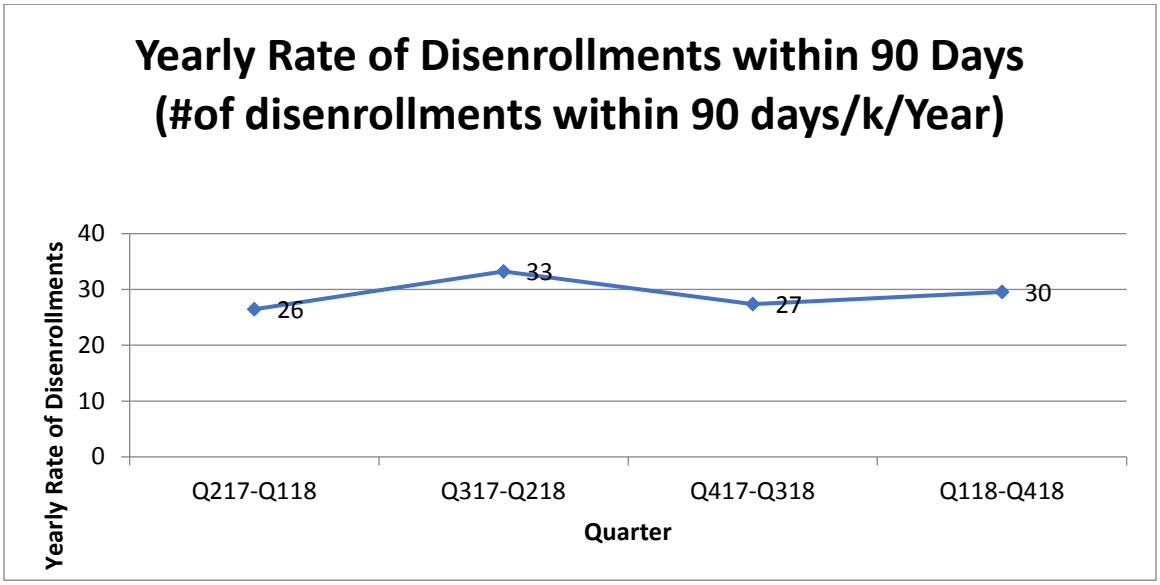
Participant Satisfaction

QAPI18.22 Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.

Goal: Reduce the annualized rate below 50/k/year (20% reduction from 2016)

Goal: Met

Data/Analysis: 30/k/year



Summary and Key Findings/Opportunities for Improvement:

We will typically see a wide fluctuation in this rate due to the small overall numbers. This year there were a total of 8 disenrollments within 90 days in 2018. One was due to death, two due to dissatisfaction with the PACE clinic and PACE program respectively, and one due to transition to hospice care. The remaining 4 disenrollments were due to eligibility issues, including no stable housing, leaving the service area and loss of Medi-Cal eligibility. We will continue to monitor disenrollments within the 90-day period. In the upcoming year, we with a focus on addressing program dissatisfaction promptly and the comprehensive review of prospective enrollees, identifying potential imminent factors affecting enrollment (i.e. stable housing, changes in eligibility).

QAPI18.23 Improve the overall satisfaction of participants and their families with the CalOptima PACE program

Goal: >88% will answer Good, Very Good or Excellent to the question, "Overall, would you rate the care you receive from PACE as:".

Goal: Met

Data/Analysis: 97% overall satisfaction with care received

2018 Participant Survey Overall Satisfaction Domains

Domain	2017	2018	2018 CalPACE
Would you recommend the program to a close friend or relative?	83%	93%	95%
Overall satisfaction with the care received	91%	97%	95%

2018 Participant Survey Domains

Domain	2017	2018	2018 CalPACE	2018 National Averages
Transportation	98%	93%	93%	95%
Center Aids	96%	92%	92%	91%
Home Care	93%	91%	87%	88%
Medical Care	92%	88%	88%	90%
Health Care Specialist	92%	90%	84%	88%
Social Worker	95%	97%	94%	95%
Meals	63%	59%	64%	72%
Rehabilitation Therapy and Exercise	97%	98%	95%	93%
Recreational Therapy	86%	77%	82%	82%
Other Indicators	94%	92%	89%	89%
Weighted Summary Score	90%	87%	88%	87%

Summary and Key Findings/Opportunities for Improvement:

In the fall of 2018, CalOptima PACE contracted with Vital Research to conduct a Participant Satisfaction Survey. 98 participants were interviewed by Vital Research to gauge the participant's satisfaction with CalOptima PACE services: Specific domains included: Medical Care, Health Care Specialists, Social Worker, Meals, Rehab Therapy and Exercise, Recreational Therapy, Transportation, Center Aids and Home Care providers.

Although PACE saw a decrease in the individual domains year over year (as well as the overall weighted score), we saw an increase in the overall satisfaction of the participants with 97% (increase of 6%) of the participants satisfied with the care that they receive at CalOptima PACE and 93% (increase in 10%) stating they would refer a friend or relative in need. Additionally, the

CalOptima PACE scores were equal to or higher than the CalPACE averages in all but two of the individual domains.

Meals provided at PACE continued to one of the lower-rated domains (59% were satisfied with the meals). CalOptima PACE continues to have a very diverse population and come to the PACE program with a variety of cultural backgrounds (15 different ethnicities) and food preferences. Looking ahead to 2019, we will be creating a new quality plan element focused on PACE participants satisfaction with meals in order to focus attention and improvement activities on meeting the diverse meal requests of our participants. Through developing partnerships with Alternative Care Sites, we are able to provide greater options to our participants. This includes environments which may be more culturally appropriate to the participant.

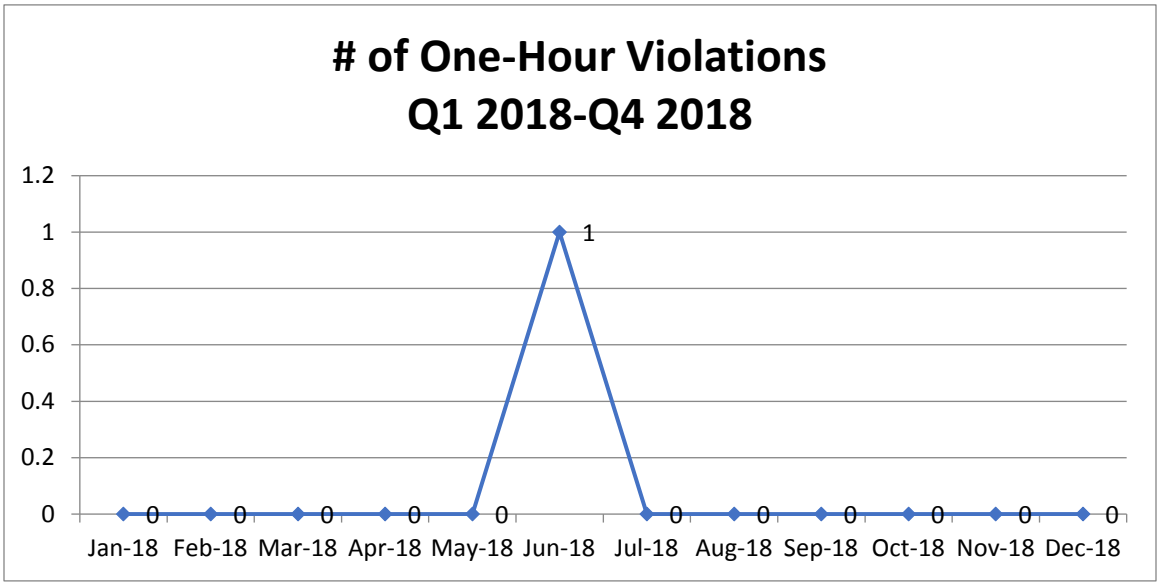
Transportation

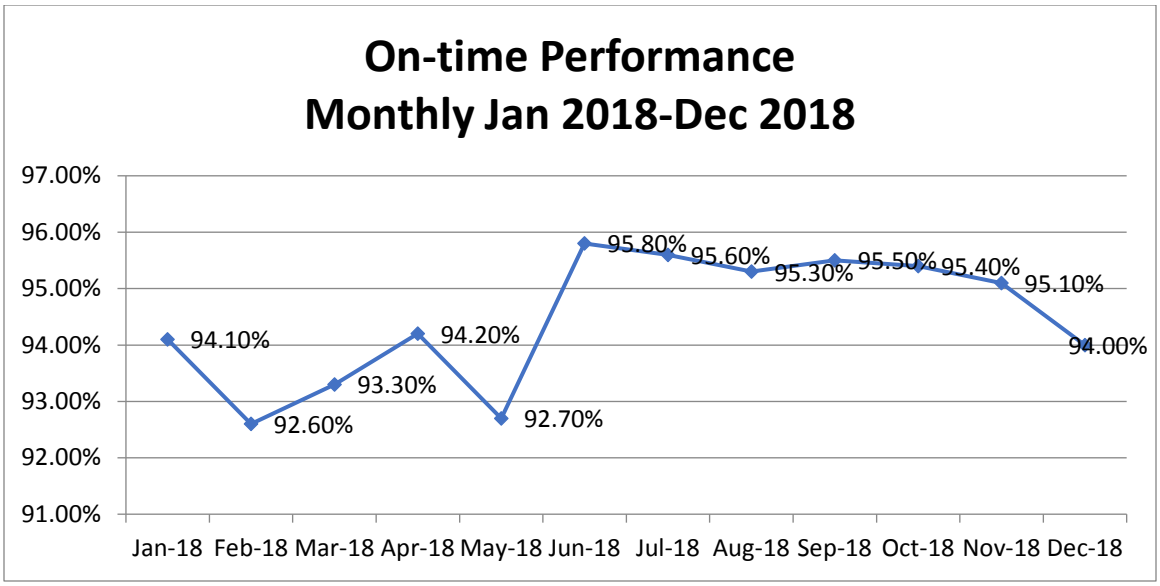
QAPI18.24 and QAPI18.25: Transportation

Goal: Ensure PACE transportation ride times are less 60 minutes per trip with a goal: 0 trips > 60 minutes in duration and improve participant experience by providing timely transportation services with a goal of > 90% on-time performance

Goal: Less than 60 minutes in ride duration: Goal Not Met
On-time performance: Goal Met

Data/Analysis: In 2018, we had one 1-hour violation which occurred in quarter 2. However, our on-time performance maintained a 95% rate.



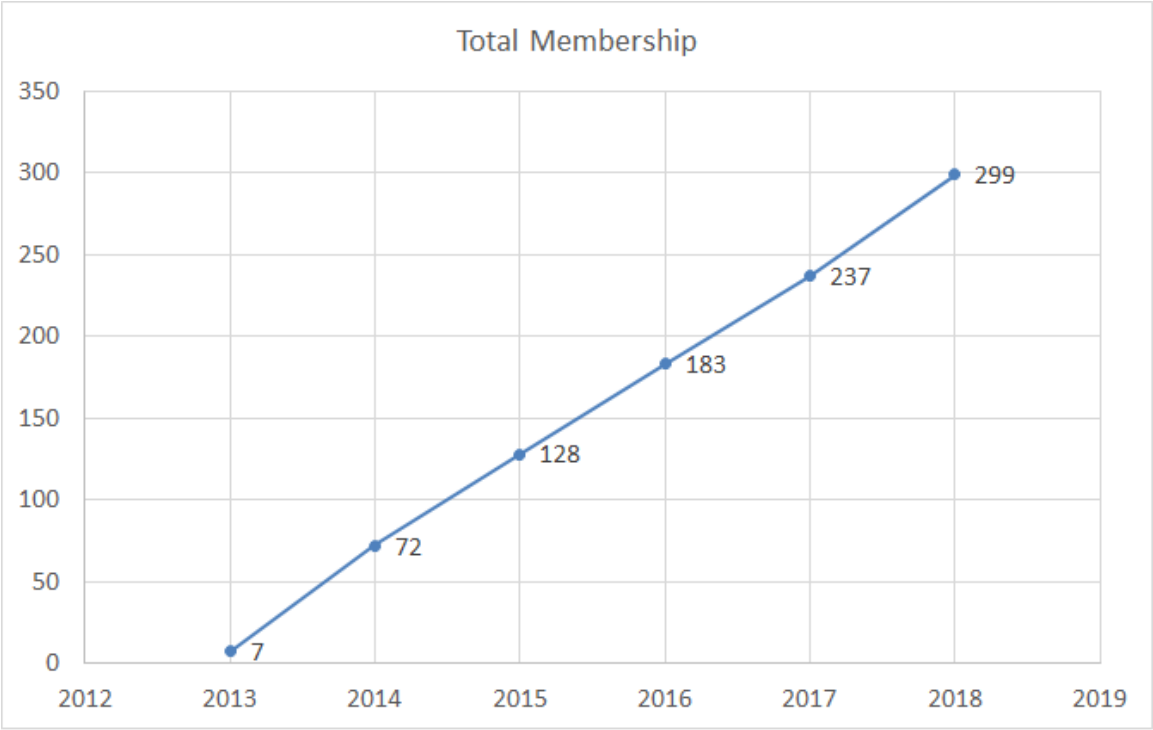


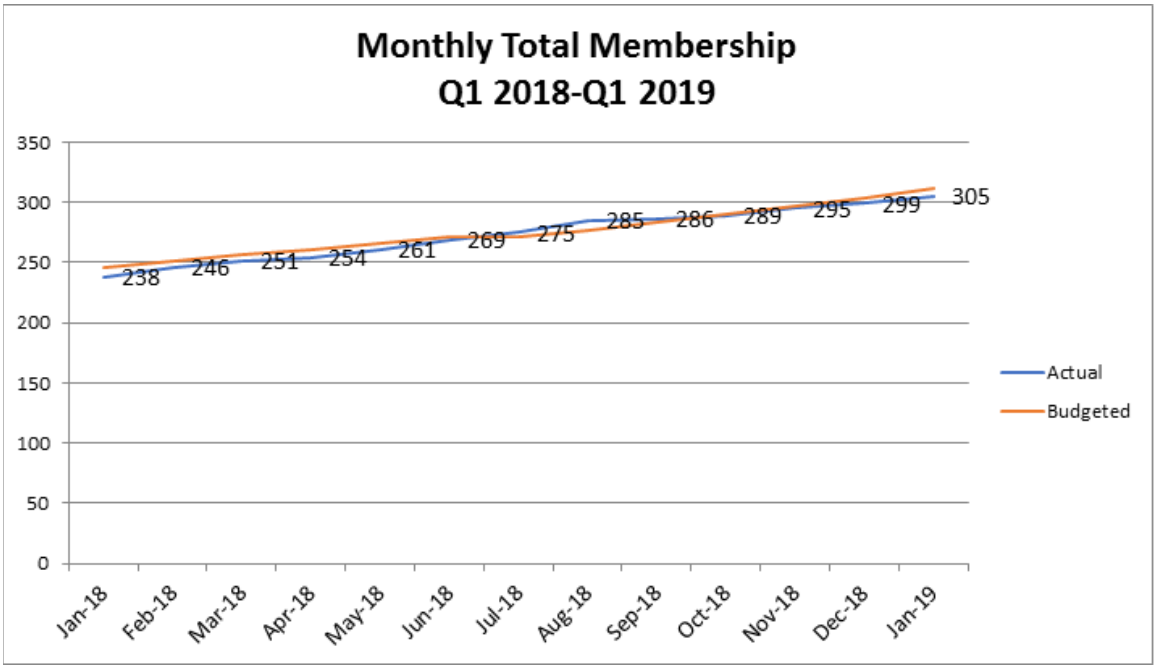
Summary and Key Findings/Opportunities for Improvement:

This goal was not met due to the single one-hour violation. Although this goal was not met, we have seen significant improvement over the last couple of years. The on-time performance, which is a lead indicator for the 1-hour violations, have consistently been in the mid-90th percentiles for most of the year. The PACE operations team will continue to meet monthly with the transportation vendor to ensure we meet these two transportation goals as we start to see an increase in participants in the northern and southern parts of the county.

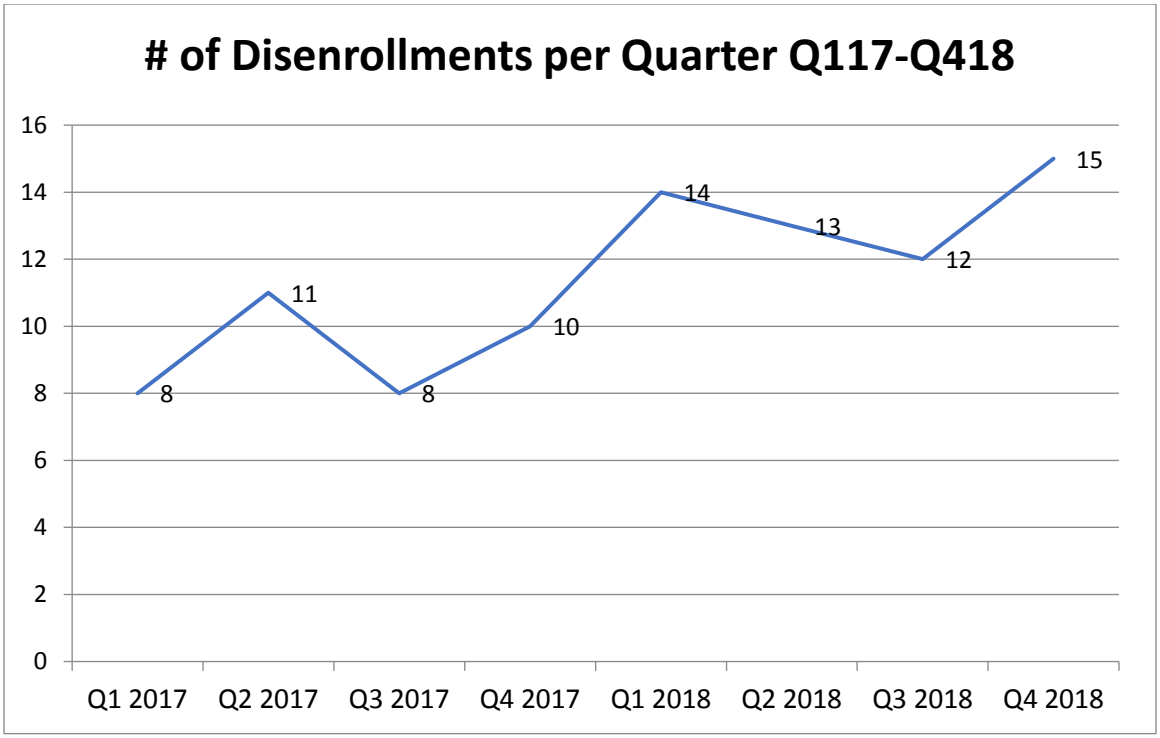
ENROLLMENT/DISENROLLMENT

2013-2018 Monthly Membership Trends





2017-2018 Disenrollment Trends



Summary and Key Findings/Opportunities for Improvement:

Over the past two years, we have seen a steady growth in net enrollment. In October 2018, we examined our capability to accommodate this growth and provide greater opportunity for the elderly population in our county. The result was the implementation of a capacity building initiative referred to as PACE 2.0. This is a nationwide PACE initiative supported by both the National PACE Association and CalPACE. This implementation required that we evaluated our organizational readiness for growth, streamlined our enrollment process, implemented improvements to decrease disenrollments and build staffing capacity. This, together with our service area expansion, developing partnerships with Alternative Care Setting sites, the involvement of community-based physicians and the expanding of our PACE at home program will allow us to grow and promote the PACE model of healthcare delivery. Looking ahead into 2019, we plan to be fully operational with the goals of the PACE 2.0 initiative.

2018 HEALTH PLAN MANAGEMENT SYSTEM (HMPS)

2018 HPMS Updates: CMS implemented changes to the Level I event and Level II reporting structure. Level I and Level II events are now referred to as Unusual Quality Incidents and are reported to CMS on a quarterly basis via the Health Plan Management System (HPMS). The following elements are reported:

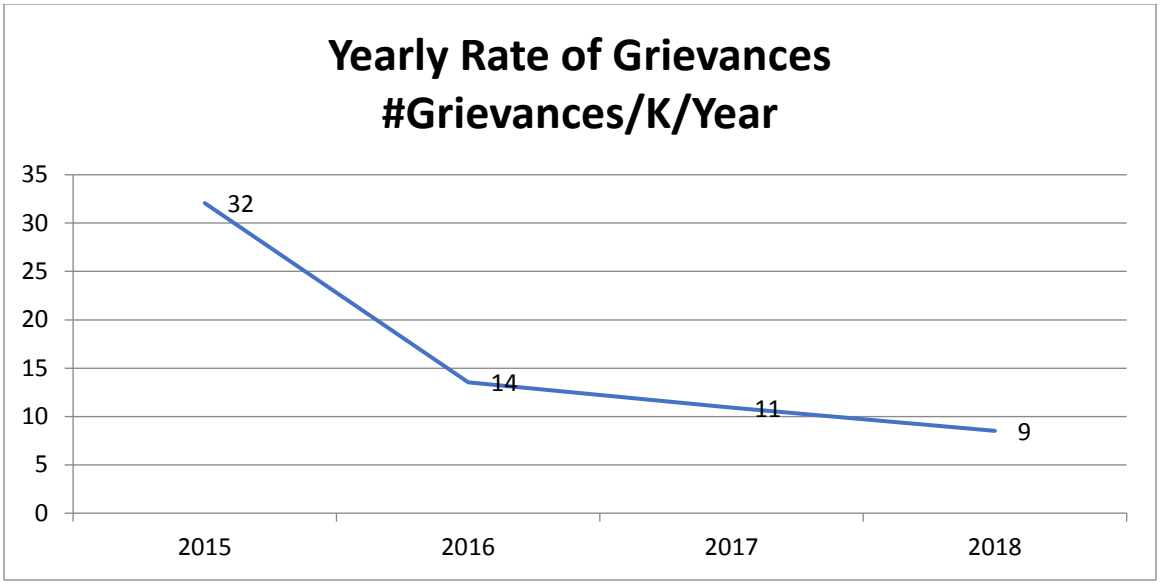
1. Grievances
2. Appeals
3. Unusual Quality Incidents (Formerly known as Level II events)
4. Medication Errors
5. Immunizations (evaluated in the Quality of Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

Grievances

Data Analysis:

	CENTER							CLINIC			
					Transportation			Clinical Care/ Service/ Treatment			
	# Grievances	Other	Food	Home Care	Timelines	Prt-Driver	Escort	Dissatisfaction	Timelines	Comm-unication about care	Scheduling/ Communication
Q4 2014	2	0									
Q1 2015	0	0									
Q2 2015	7	0	1	1	1	0	0	1	1	1	1
Q3 2015	17	0	0	0	4	1	2	3	4	1	1
Q4 2015	13	0	0	0	1	1	1	8	1	0	1
Q1 2016	1	0	0	0	0	0	0	0	0	0	1
Q2 2016	7	0	0	0	4	0	0	2	0	0	1
Q3 2016	6	0	0	0	2	1	0	1	0	0	2
Q4 2016	4	0	0	0	0	2	0	0	2	0	0
Q1 2017	9	0	0	1	0	0	0	3	1	1	3
Q2 2017	2	0	0	0	2	0	0	0	0	0	0
Q3 2017	10	0	0	0	7	0	0	2	1	0	0
Q4 2017	6	1	0	0	2	1	0	1	0	0	1
Q1 2018	10	1	0	0	2	1	0	2	2	0	2
Q2 2018	4	0	1	0	0	0	0	2	0	1	0
Q3 2018	5	0	0	0	1	0	0	3	0	1	0
Q4 2018	1	1	0	0	0	0	0	0	0	0	0

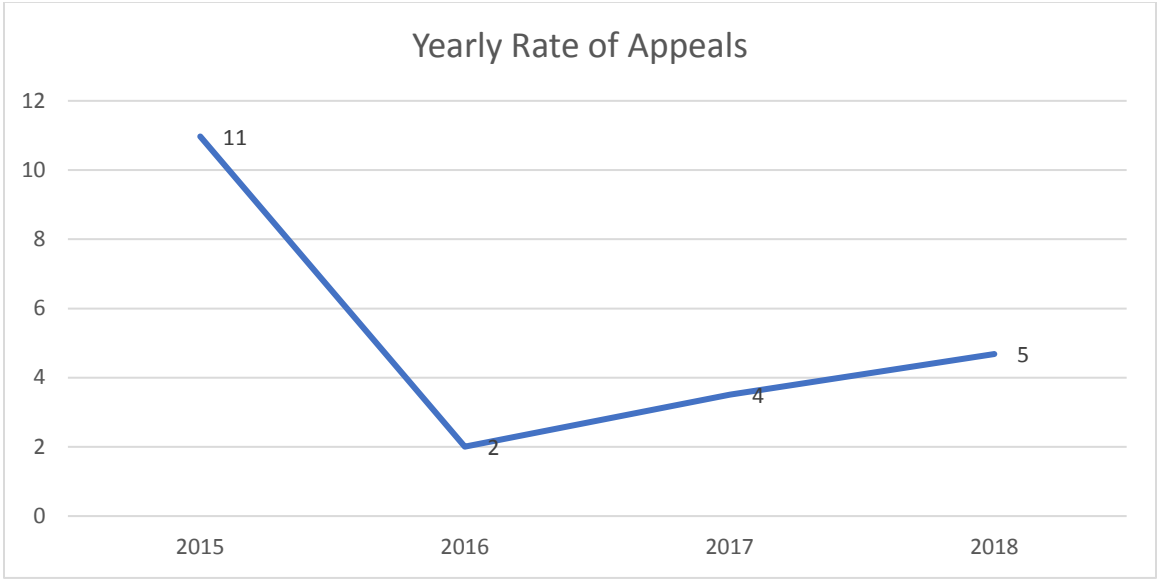
Annualized Rate of Grievances 2015 - 2018



Overall grievance rates remained stable in 2018. The low numbers of grievances received do not allow us to statistically trend any significant issues. However, our 2018 Participant Satisfaction Survey results indicated that participants were very satisfied with the care provided. We will closely monitor grievances as we continue to expand our partnerships with outside vendors and providers to ensure that high quality care is being provided our participants in all settings. Additionally, it will allow us to proactively address issues that may arise as we further expand throughout the county.

Appeals

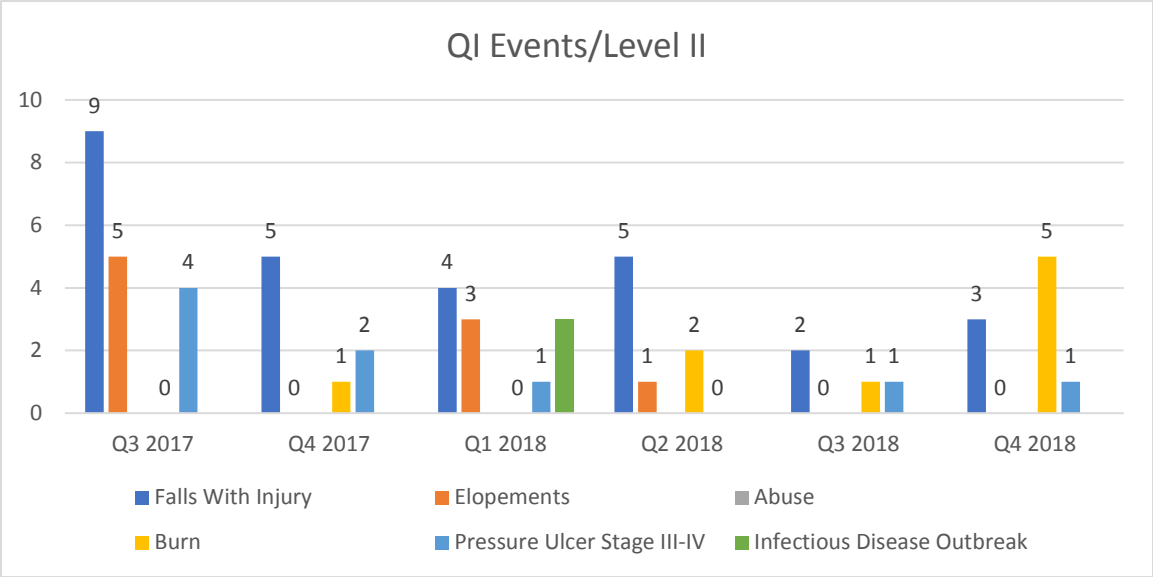
Data Analysis:



Appeals by participants continue to be minimal in 2018. A total of 5 appeals were submitted in 2018, the majority concerning requests for increased center day attendance. The processing of Service Delivery Requests is an area of focus for the Interdisciplinary Care Team. The PACE Center Manager will be providing a monthly report to the PACE Leadership Team and will be reported and followed closely in the PACE Quality Improvement Committee (PQIC) meetings.

Level II Events/Unusual Quality Incidents

Data Analysis:



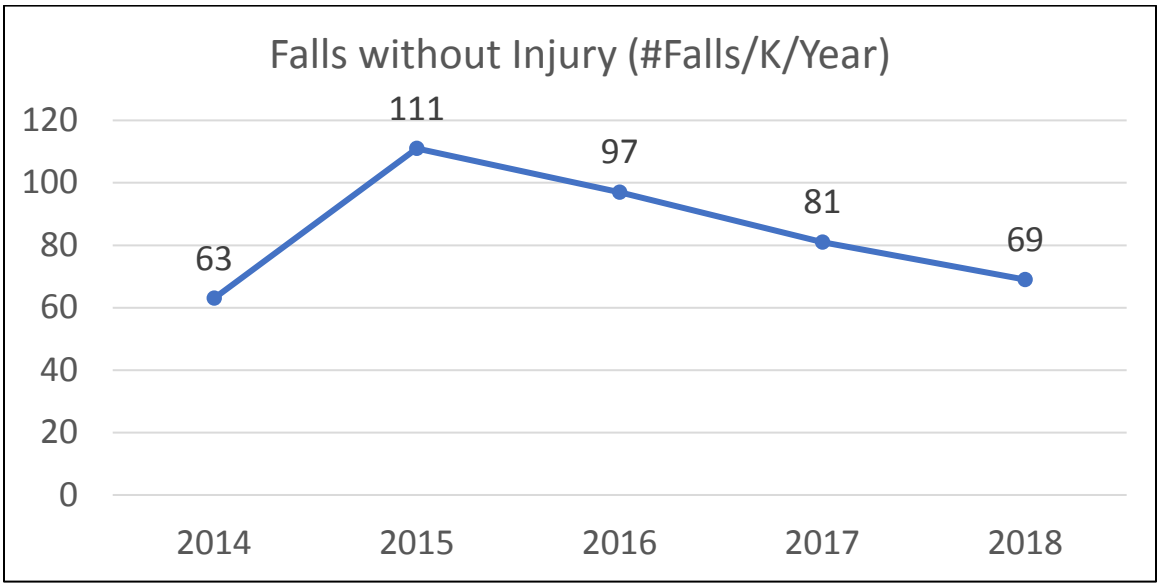
No significant trends were found in the Level II Events/Unusual Quality Incidences. A total of 8 burns (second degree or less) were reported in 2018. Burns most often occurred in the home environment. Although the resulting root cause analysis did not show any systemic operational issues, it did result in two education and training sessions for the staff members who were involved in a medication error and a participant fall.

Medication Errors

A total of 12 medication errors were reported in 2018. Most errors were attributable to staff errors. In response, internal corrective action plans were implemented which involved staff training and a performance improvement plan.

Falls Without Injury

Data Analysis:



Calculated as a rate utilizing member months. There have been some progressive improvements from the number of reported falls without injury from 2015 onwards. Most falls are continuing to occur in the community, specifically in the participant's home environment. CalOptima PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal to decrease in the numbers of falls in 2018 and continuing into 2019. Ongoing falls prevention groups include:

1. *PACE Fall Committee*: Comprised of PACE Rehabilitation staff which reviews those participants who have incurred a fall.
2. *PACE Fall Prevention*: Comprised of PACE participants who are educated by the Rehabilitation staff in fall recovery mechanisms.
3. *Fallers Anonymous*: Comprised of PACE participants who meet quarterly with the Rehabilitation team to discuss safety in the home and environment
4. *Matter of Balance*: Targets those participants with cognitive impairment. Discusses the many misconceptions surrounding falls.

Denials of Prospective Enrollees

Three prospective enrollees were denied enrollment. Two were denied by the State and one was denied by PACE. All three were due to safety concerns.

VI. OPPORTUNITIES FOR IMPROVEMENT IN 2019

1. Improve the Quality of Care (QOC) for Participants
    a. New QOC elements will be added to the 2019 QI work plan.
        i. Reduce the Rate of Day Center Falls.
        ii. Use of Opioids at High Dose (UOD)
        iii. Identification of family member on Advanced Care Planning Directive.
    b. Bundle Comprehensive Diabetes Care (CDC) QOC elements to give providers a single diabetes element to monitor.
    c. Refine provider incentive program.
    d. Further develop the Operational/Utilization dashboard to reflect the oversight needed as PACE expands Alternative Care Setting (ACS) partners.
2. Ensure the Safety of Clinical Care
    a. New Use of Opioids at High Dose (UOD) element to ensure the appropriate monitoring of high dose opioids.
    b. Increase the % of specialty medications which are reviewed in real time.
    c. The QI team will focus on strengthening oversight activities of external providers and vendors specifically related to home care, skilled nursing facilities, board and care facilities and transportation.
    d. The grievances and potential quality issues involving downstream vendors will be track and trended to assure no service or clinical trend is emerges.
3. Ensure the Appropriate Use of Resources
    a. Inpatient/ER Utilization
        i. The ER Diversion Program will be fully implemented in 2019.
        ii. We will implement our End of Life Care team consisting of a case manager, social worker and our Palliative Care PCP.
        iii. Further expansion of our complex case management program with individualized interventions.
    b. Specialty Care
        i. Increase the number of preferred specialists and provide training in the PACE Model of Care. Preferred specialists will attend some IDT meetings and, if possible, will see participants at the PACE center.
        ii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.
        iii. Optometry and Tele-Psychiatry will be brought into the PACE center.
    c. Pharmacy
        i. Retrospective quarter reviews of medication utilization will be analyzed and shared with IDT and the PACE PCP's.
4. Improve Participant Experience
    a. Participants will be updated on the Satisfaction Survey process.
    b. The PACE QI team will survey a sample of participants monthly and use the metrics as a lead indicator and help find opportunities for improvement.
    c. New participant satisfaction element will be added to focus specifically on meals.
    d. The grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement.

5. Ensure Appropriate Access and Availability
    a. Full implementation of the PACE 2.0 initiative.
    b. New enrollment element: Increase Inquiry to Enrollment Conversion
    c. Expansion of ACS sites.
    d. Expansion of Community PCPs
    e. Expansion of PACE at Home program.

2018 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q2 Results	Q3 Results	Q4 Results	EOY Total	MET/NOT MET
QAPI18.01	Quality of Care	2017 PACE QAPI Plan and Work Plan Annual Evaluation	PACE QAPI Plan and Work Plan will be evaluated annually.	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	PACE Medical Director	Annually	March, 2018	Completed	Completed	Completed	Completed		Met
QAPI18.02	Quality of Care	2018 PACE QAPI Plan and Work Plan Annual Oversight	PACE QAPI Plan and Work Plan will be reviewed and updated annually	QAPI and QAPI Work Plan will be approved and adopted on an annual basis	Annual Adoption	PACE Medical Director	Annually	March, 2018	Completed	Completed	Completed	Completed		Met
QAPI18.03	Quality of Care	Influenza Immunization Rates	Increase Influenza immunization rates for all elig ble PACE participants	Improve compliance with influenza immunization recommendations	> 90% of members will have influenza vaccination	Clinical Operations Manager	Quarterly	12/31/2018	89%	NA	NA	98%	98%	Met
QAPI18.04	Quality of Care	Pneumococcal Immunization Rates	Increase Pneumococcal immunization rates for a l eligible PACE participants	Improve compliance with pneumococcal immunization recommendations	> 90% of members will have pneumococcal vaccination	Clinical Operations Manager	Quarterly	12/31/2018	90%	98%	94%	90%	90%	Met
QAPI18.05	Quality of Care	Infection Control	Reduce common infections in PACE participants (Respiratory and Skin)	Monitor and analyze the incidence of Respiratory and Skin infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement	Maintain common infection rates less than the following national benchmarks Respiratory Tract 0.1 2.4 episodes/1000 participant days. Skin and Soft Tissue 0.1-2.1 episodes/1000 participant days	Clinical Operations Manager	Quarterly	12/31/2018	Respiratory Tract .63 episodes/k participant days Skin/Soft Tissue .45 episodes/k participant days	Respiratory Tract .30 episodes/k participant days Skin/Soft Tissue .42 episodes/k participant days	Respiratory Tract .16 episodes/k participant days Skin/Soft Tissue .32 episodes/k participant days	Respiratory Tract .38 episodes/k participant days Skin/Soft Tissue .45 episodes/k participant days	Respiratory Tract .36 episodes/k participant days Skin/Soft Tissue .41 episodes/k participant days	Met
QAPI18.06	Quality of Care	Care for Older Adults: Advance Directive Planning	Increase POLST uti ization for PACE participants	Ensure a l PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST uti ization	>75% of members who have been enro led in the PACE program for 6 months will have a POLST completed	PACE Center Manager	Quarterly	12/31/2018	100%	100%	100%	100%	100%	Met
QAPI8.07	Quality of Care	Care for Older Adults: Medication Review (COA)	Increase the percentage of PACE participants who have their medications reviewed	Ensure a l PACE participants have a medication review	100%	PACE Center Manager	Quarterly	12/31/2018	100%	93%	100%	100%	100%	Met
QAPI18.08	Quality of Care	Care for Older Adults: Functional Status Assessment (COA)	Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS.	Ensure a l PACE participants have a functional status assessment completed by the required discip ines every 6 months	100%	PACE Center Manager	Quarterly	12/31/2018	100%	100%	98%	100%	100%	Met
QAPI18.09	Quality of Care	Care for Older Adults: Pain Screening (COA)	Increase the percentage of PACE participants who are screened regularly for pain.	Ensure a l PACE participants have a pain screening	100%	PACE Center Manager	Quarterly	12/31/2018	100%	94%	94%	100%	100%	Met
QAPI18.10	Quality of Care	Comprehensive Diabetes Care (CDC): Diabetic Eye Exams	Increase the percentage of PACE participants w th diabetes who get their annual diabetic eye exam completed	PACE participants with diabetes w ll be monitored by the PACE QI department who will work w th the interdisciplinary and clinical teams to develop strategies for improvement	> 83.10% (MEDICARE Quality Compas - 2016 HEDIS 90th percentile)	PACE Medical Director	Quarterly	12/31/2018	96%	97%	97%	90%	90%	Met
QAPI18.11	Quality of Care	Comprehensive Diabetes Care (CDC): Nephropathy Monitoring	Increase the percentage of PACE participants w th diabetes who receive nephropathy monitoring.	PACE participants with diabetes w ll be monitored by the PACE QI department who will work w th the interdisciplinary and clinical teams to develop strategies for improvement	>98.30% (MEDICARE Qual ty Compas - 2016 HEDIS 90th percent le)	PACE Medical Director	Quarterly	12/31/2018	93%	100%	92%	92%	96%	Not Met
QAPI18.12	Quality of Care	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)	Increase the percentage of PACE participants w th diabetes who have contro led blood pressured (<140/90 mm hg)	PACE participants with diabetes w ll be monitored by the PACE QI department who will work w th the interdisciplinary and clinical teams to develop strategies for improvement	>79.32% (MEDICARE Qual ty Compas - 2016 HEDIS 90th percent le)	PACE Medical Director	Quarterly	12/31/2018	100%	99%	99%	99%	100%	Met
QAPI18.13	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus Tricyclic Antidepresants or Antipsychotics	Reduce potentially harmful drug-disease interactions	PACE participants with a history of falls w ll be monitored by the PACE QI department who will work w th the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	<38.91% (Qual ty Compas - 2016 HEDIS 90th percentile)	PACE Pharmacist	Quarterly	12/31/2018	NA	NA	NA	NA	48%	Not Met
QAPI18.14	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	Reduce potentially harmful drug-disease interactions	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdiscip inary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	<37.50% (Quality Compas - 2016 HEDIS 90th percentile)	PACE Pharmacist	Quarterly	12/31/2018	NA	NA	NA	NA	24%	Met
QAPI18.15	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	Reduce potentially harmful drug- disease interactions	PACE participants with a diagnosis of Chronic Renal Fa lure will be mon tored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	<3.70% (Quality Compas - 2016 HEDIS 90th percentile)	PACE Pharmacist	Quarterly	12/31/2018	NA	NA	NA	NA	1%	Met
QAPI18.16	Quality of Care	Medication Reconcilliation Post Discharge (MRP)	Increase the percentage of participants for whom medications were reconc led within 30 days of hospital discharge	The PACE QI Department w ll work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	>90%	PACE Pharmacist	Quarterly	12/31/2018	96%	96%	91%	95%	95%	Met

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QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q2 Results	Q3 Results	Q4 Results	EOY Total	MET/NOT MET
QAPI18.17	Access and Availability	Specialty Care	Improve access to specialty practitioners	Appointments for specialty care will be scheduled within 10 days to improve access to specialty care for initial consultations	> 80% of specia ty care authorizations will be scheduled within 10 days	PACE Clinical Operations Manager	Quarterly	12/31/2018	88%	90%	87%	87%	88%	Met
QAPI18.18	Utilization Management	Acute Hospital Day Utilization	Reduce the rate of acute hospital days by PACE participants	PACE participants hospital days will be mon tored and analyzed by the PACE QI department who will work w th the PACE interdiscip inary and clinical teams to develop strategies to lower that rate through preventative care and education	< 2,104 hospital days per 1000 per year (CalPACE avg in 2015) <2590 as FY 18	PACE Medical Director	Quarterly	12/31/2018	2958/k/year	3285/k/year	3277	3067	3067	Not Met
QAPI18.19	Utilization Management	Emergency Room Utilization	Reduce the rate of ER ut lization by PACE participants	ER ut lization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 458 emergency room visits per 1000 per year (CalPACE avg in 2015)	PACE Medical Director	Quarterly	12/31/2018	820/k/year	930	993	975	975	Not Met
QAPI18.20	Utilization Management	30 Day All Cause Readmission Rates	Reduce the 30-day a l cause readmission rates by PACE participants	30-day all cause readmission rates for hospitalized PACE participants wi l be monitored and analyzed by the PACE QI department who will work w th PACE interdiscip inary and clinical teams to find opportunities for quality improvement	<10% 30-day all cause readmission (CalOptima PACE avg in 2016)	PACE Medical Director	Quarterly	12/31/2018	12%	6%	6%	14%	10%	Met
QAPI18.21	Utilization Management	Long Term Care Placement	Decrease the percentage of participants who are placed in a long term care facil ty	PACE participants placed in long term care wi l be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	<4% of members (Ca PACE ut lization in 2016) will reside in long term care	PACE Center Manager	Quarterly	12/31/2018	0%	0%	1%	<1%	<1%	Met
QAPI18.22	Participant Satisfaction	Disenrollments	Reduce the percentage of participants who disenro l for controllable reasons from the PACE program within the first 90 days of enro lment.	Review and analyze the participants who disenrolled from PACE w thin 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Reduce the annua ized rate below 50/k/year (20% reduction from 2016)	PACE Center Manager	Quarterly	12/31/2018	26/k/year	28/k/year	27/k/year	30/k/year	30/k/year	Met
QAPI18.23	Participant Satisfaction	Overall Satisfaction	Improve the overall satisfaction of participants and their families with the CalOptima PACE program	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	>88% wi l answer Good, Very Good or Exce lent on this question (2017 CalPACE average)	PACE Director	Annually	12/31/2018	NA	NA	NA	NA	97%	Met
QAPI18.24	Delegation Oversight	Transportation	Improve PACE transportation ride times to less than 60 minutes per trip	Ensure a l PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	0 trips > 60 minutes in duration	PACE Director	Quarterly	12/31/2018	0 trips over 60 min	1 trip over 60 min	0 trips over 60 min	0 trips over 60 min	1 trip over 60 min	Not Met
QAPI18.25	Delegation Oversight	Transportation	Improve participant experience by providing timely transportation services	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports by sampling GPS records and monthly ride-along	>90% on-time performance	PACE Director	Quarterly	12/31/2018	93.33%	94.23%	95.50%	94.00%	95%	Met

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 20, 2019
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

7. Consider Recommending Board of Directors' Approval of the 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action

Recommend Board of Directors' approval of the 2019 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a PACE Provider on October 7, 2010. The CalOptima PACE program opened its doors for operation in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents and continues to grow. As of December 31st, 2018, CalOptima PACE had 299 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

Discussion

PACE organizations are required to have a written Quality Assessment and Performance Improvement (QAPI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QAPI Plan reflects the full range of services furnished by CalOpima PACE. The goal of the QAPI Plan is to improve future performance through effective improvement activities driven by identifying key, objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.

The 2019 CalOptima PACE QAPI Plan is based on CalOptima's first five full years of data collection, review and analysis with specific data driven goals and objectives. The work plan elements were developed based on the opportunities for quality improvement that were revealed in the 2018 CalOptima PACE QAPI Plan Evaluation. For the 2019 QAPI work plan, five new elements were added, two elements were retired, and three elements were bundled into one element. The added elements are focused on reducing falls, increasing participant satisfaction with meals, increasing the inquiry to enrollment conversion, monitoring participants on high dosages of opioids and identifying a

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family member who can make decisions in emergency situations. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

The recommend action to approve the 2019 CalOptima PACE QAPI Plan does not have a fiscal impact. Administrative expenses to implement the 2019 PACE QAPI Plan are included in the Board-approved Fiscal Year 2018-19 Consolidated Operating Budget.

Rationale for Recommendation

PACE organizations are required to establish a Quality Assessment and Performance Improvement (QAPI) program. Through 42 CFR §460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE Organizations to have their QAPI plan reviewed annually by the PACE governing body and, if necessary, revised. As per 42 CFR §460.132(a) and (b), the PACE organization leadership presents their QAPI plan and any revisions to their governing body for annual approval to assure effective organizational oversight. CMS and the State will review the plan during subsequent monitoring visits.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed 2019 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Plan and QAPI Work Plan
2. PowerPoint Presentation: 2019 PACE QAPI Description and Work Plan

/s/ Michael Schrader — *2/14/2019*

Authorized Signature — **Date**

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CALOPTIMA PACE

QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN

20198

Quality Improvement Subcommittee Chairperson:

~~Richard Helmer~~David Ramirez, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

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

Board of Directors Chairperson:

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

Introduction

The Quality Assessment Performance Improvement Plan (QAPI) at CalOptima's Program of ~~All Inclusive~~All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous quality improvement for all the PACE organizations' services. ~~-~~It is designed and organized to support the mission, values, and goals of CalOptima PACE.

Overview

- The goal~~s~~ of the CalOptima PACE QAPI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QAPI Plan is developed by the PACE Quality Improvement Committee (PQIC). ~~-~~As CalOptima's governing body, the Board of Directors has the final authority to review and~~,~~ approve ~~and, if necessary, revise~~ the QAPI Plan annually, and direct the PACE Medical Director to make revisions to the QAPI Plan, as necessary and appropriate. (See Appendix A).~~-~~ It is comprised of both the PACE QAPI Program Description and specific goals and objectives described in the PACE QAPI Work Plan. (See Appendix B).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QAPI Plan. ~~-~~The PACE QI Coordinator will ensure timely collection and completeness of data.
- The CalOptima PQIC~~PACE QAPI Committee~~ will complete an annual evaluation of the approved QAPI Plan. ~~-~~This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QAPI Plan to the goals and objectives for the following year.

~~Goals~~

- ~~To provide quality health care services for all CalOptima PACE participants through comprehensive service delivery leading to improved clinical outcomes~~
- ~~To coordinate all QAPI activities into a well-integrated system that oversees quality of care services~~
- ~~To achieve a coordinated ongoing and effective QAPI Program that involves all providers of care~~
- ~~To ensure that all levels of care are consistent with professionally recognized standards of practice~~
- ~~To assure compliance with regulatory requirements of all responsible agencies.~~
- ~~To promote continuing education and training of staff, practitioners, administration and the executive board~~
- ~~To analyze data and studies for outcome patterns and trends~~
- ~~To annually assess the effectiveness of the QAPI Plan and enhance the program by finding opportunities to improve the CalOptima PACE QAPI Plan~~

~~Objectives~~Goals

- Improve the quality of health care for participants.
  - Ensure all QAPI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
  - Ensure the QAPI program ~~that~~ involves all providers of care within the PACE program.
  - ~~Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE Staff will be measured against those outlined by their respective licensing agency in the State of California (i.e. The State Board of Nursing of California).~~
  - Implement population health management techniques, such as immunizations, for specific participant populations~~, such as immunizations~~.
  - Identify and address areas for improvement that arise from unusual incidents, sentinel events, and annual death review.
  - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) in order to identify areas needing of quality improvement.
  -
  - Meet or exceeds minimum levels of performance on standardized quality measures as established by CMS and the state administering agencies (SAA) which includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 98~~0~~% for the appropriate participant population ~~that is appropriate~~.
  - Communicate relevant ~~all~~ QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
  - Share r~~R~~esults of QAPI-identified benchmarks ~~are shared~~ with staff and contracted providers at least annually.
  -
  - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. ~~-~~Professional standards of CalOptima PACE ~~S~~staff will be measured against those outlined by their respective licensing agency~~y~~ies in the State of California (i.e. ~~The~~ State Board of Nursing of California).
  - ~~To provide quality health care services for all CalOptima PACE participants through comprehensive service delivery leading to improved clinical outcomes~~
  - ~~To coordinate all QAPI activities into a well integrated system that oversees quality of care services~~
  - ~~To achieve a coordinated ongoing and effective QAPI Program that involves all providers of care~~
  - E~~To e~~nsure that all levels of care are consistent with professionally recognized standards of practice.
  - A~~To a~~ssure compliance with regulatory requirements of all responsible agencies.
- ~~To promote continuing education and training of staff, practitioners, administration and the executive board~~

-
- Improve ~~on~~ the participant~~tient~~ experience.
  - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
  - Provide education to staff on the multiple dimensions of patient experience.
  - Identify and implement ways to better engage participants in the PACE experience, i.e., menu selection~~,~~ and ~~PACE Member Advisory Committee (~~PMAC~~)~~.
  - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
  - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) which honors members' wishes as well as advance directive rights..
- Ensure the ~~A~~appropriate ~~U~~use of ~~R~~resources.
  - Review and analyze utilization data regularly, including hospital admissions, hospital readmissions, ~~ER~~Emergency Room visits, and hospital 30-day all-cause readmissions, to identify high-risk members and opportunities for improvement.
  - Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing-basis.
  - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs)~~s~~.
  - ~~o~~ Ensure high levels of coordination and communication between ~~the~~ inpatient facilities, nursing facilit~~y~~ies and ~~the~~ PACE ~~primary care physicians~~PCPs.
  -
  - ~~o~~ Review and analyze clinic medical records to ensure appropriate documentation and coding.
  - ~~o Ensure appropriate use of resources~~
  - ~~o Review and analyze utilization data regularly including hospital admissions, hospital readmissions, ER visits, and hospital 30-day all-cause readmission.~~
  - ~~o~~
  - ~~o Provide oversight of contracted services~~
  - ~~o Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.~~
  - ~~o Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.~~
  - ~~o Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing basis.~~
  - ~~o Monitor staff and contractors to ensure that appropriate standards of care are met.~~
  - ~~o~~
  - ~~o Communication of Quality and Process Improvement Activities and Outcomes~~
  - ~~o Communicate all QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee, and the Board of Directors.~~
  - ~~o Results of QAPI identified benchmarks are shared with staff and contracted providers at least annually.~~

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- Ensure the ~~S~~safety of ~~C~~clinical ~~C~~care
  - Reduce potential risks to safety and health of PACE participants through ongoing r~~R~~isk m~~M~~anagement.
  - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
  - ~~Monitor, analyze and report the aggregated data elements required by CMS via the Health Plan Management System in order to identify areas needing of quality improvement.~~
  - Monitor, report and perform a Root Cause Analysis on all participant-involved events~~,~~ resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
  - Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.
  - Monitor staff and contractors to ensure that appropriate standards of care are met.
- Ensure appropriate access and availability.
  - ~~Continuously m~~Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
  - Continue to develop the network of Alternate Care Setting sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure (See Appendix A for Organizational Chart)
CalOptima Board of Directors provides oversight and direction to the CalOptima PACE Organization. ~~-~~The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QAPI Plan efforts to flourish. ~~-~~The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the quality improvement (QI) programs at CalOptima, including ~~. This includes~~ the CalOptima PACE QAPI Program, to the CalOptima Board of Director~~'~~s' Quality Assurance Committee (QAC), which performs the functions of the Quality Improvement Committee (QIC) described in CalOptima's State and Federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The CalOptima Board of Director~~'~~s' QAC is a subcommittee of the Board, and consists of currently active Board members. ~~-~~The CalOptima Board of Director's QAC reviews the quality and utilization data that are discussed during the PACE Quality Improvement Committee (PQIC) reports. ~~-~~The CalOptima Board of Director's QAC provides progress reports, reviews the annual PACE QAPI Plan and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

CalOptima PACE Quality Improvement Committee (PQIC)

Purpose

This committee provides oversight for the overall administrative and clinical operations of ~~the~~ CalOptima ~~organization~~PACE. ~~-~~The PQIC may create new committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. Twice a quarter, ~~-~~the PQIC will review all QAPI ~~Plan~~ initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. ~~-~~The PQIC may create Ad Hoc Focus Review Committees for limited time periods in order to address quality problems in any clinical or administrative process. ~~-~~It will also discuss Unusual Quality Incidents~~Level One data and Level Two data and incidents~~.~~-~~ Potential areas for improvement will be identified through analysis of the data and through ~~Level Two~~ root cause analysis. ~~-~~This meeting will be facilitated by the PACE Medical Director who will report its activities up to the CalOptima Board of Director~~'~~s' QAC, who will then report up to the Board.~~-~~ The PACE Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence.~~-~~ The PACE Director or the PACE QI Manager ~~A Coordinator~~ may report up to the CalOptima Board of Director~~'~~s' QAC if the PACE Medical Director is not available.

Membership

Membership shall be ~~comprise~~comprised of the PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager~~, PACE Clinical Medical Director~~, PACE QI ~~A~~ Manager~~, the~~ PACE ~~and the~~ QI ~~A~~ Coordinator, and PACE Intake/Enrollment Manager. ~~-~~At least four regular members shall constitute a quorum. ~~-~~The PACE Medical Director will act as the standing c~~C~~hair of the committee. See Appendix C for QI Committee Minutes Template.

CalOptima PACE Focused Review Committees

Purpose

These committees will be formed to respond to or to proactively address specific quality issues ~~which~~ that rise to the level of warranting further study and action. ~~-~~Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

Membership

Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to ~~-~~include at least two of the following positions and/or functions: PACE Medical Director~~, PACE Clinical Medical Director~~, PACE QI~~A~~ Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI~~A~~ Coordinator, and PACE Intake/Enrollment ~~Coordinator~~ Manager or direct care staff.~~-~~ The Committee will be chaired by the PACE Medical Director~~, PACE Clinical Medical Director~~, ~~-~~PACE Director or PACE QI~~A~~ Manager. ~~-~~The chair will report on activities and results to the PQIC. ~~-~~The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC. ~~-~~This c~~C~~ommittee will be responsible for managing all peer review activities performed by independent reviewers related to adverse outcomes.

CalOptima PACE Member Advisory Committee (PMAC)

Purpose
This committee provides advice to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. -A member of the PMAC shall report its activities to ~~both the PQIC and~~ the CalOptima Board of Directors'~~,~~ QAC, which then will be reported to the Board. -The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. -Participants and representatives of participants shall constitute a majority of membership. -The committee will be comprised of at least seven members. -At least four regular members shall constitute a quorum. -The PACE Program Director will act as the standing c~~C~~hair and will facilitate for the committee. -The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

Quality and Performance Improvement Activities, Outcomes and Reporting

Quality ~~I~~indicators and ~~O~~opportunities for i~~I~~mprovement
Routine quality indicators appropriate to the CalOptima PACE population are identified on analysis and trending of data related to the care and services provided at PACE. -Other indicators and opportunities for performance improvement are identified through:

- Utilization of s~~S~~ervices
    - CalOptima PACE will collect, analyze and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
        - Hospital Bed Days
        - ER Visits
        - 30-Day All-Cause Readmissions
        - Participants residing in Long-~~-~~Term Care
    - Data analysis will allow for analyzing both overutilization and ~~under utilization~~underutilization for areas of quality improvement.
- Participant and ~~C~~caregiver ~~S~~satisfaction
    - The organization shall survey the participants and their caregivers on at least an annual basis. -Additionally, the organization~~we~~ will ~~continue to~~ look for other opportunities for feedback in order to improve quality of services.
    - Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
    - The ~~PACE Member Adviosory~~Advisory ~~Committee~~PMAC shall provide direct ~~feeback~~feedback on satisfaction to both the PACE leadership staff and the CalOptima Board of Directors~~,~~' ~~Quality Assuarnace~~Assurance ~~Committee~~QAC.
- Outcome m~~M~~easures f~~F~~rom the QAPI W~~w~~ork P~~p~~lan elements ~~as well as the~~and ~~elininically~~clinically ~~relavant~~relevant HPMS data. This will include:

- ~~This will include t~~The CMS mandated immunization elements.
- Healthcare Effectiveness Data and Information Set (HEDIS) metrics ~~relavent~~relevant to the PACE population including:
  - Comprehensive Diabetes Care (CDC)
  - Care for Older Adults: Advanced Care Planning
  - Potentially Harmful Drug-Disease ~~Interations~~Interactions in the Elderly (DDE)
  - Medication ~~Reconcilliation~~Reconciliation Post Discharge (MRP)
  - ~~Opioids at High Dosage (UOD)~~
  -
- ~~Annual Medication Review~~

Physiological and clinical well-being, functional status, cognitive functioning, and emotional and mental health status assessments may be used. ~~-~~Standardized, evidenced~~-~~based assessments will be used whenever available.

-

- Effectiveness and safety of staff-provided and contract-provided services.
  - This will be measured by participants~~'~~' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, review of medical records, and success of infection control efforts.
  - All clinical and certain non-clinical positions have competency profiles specific to their positions.
  - CalOptima PACE staff will monitor providers by methods such as review of providers' quality improvement activities, medical record review, grievance investigations, observation of care, and interviews.
  - Unannounced visits to inpatient provider sites will be made by CalOptima PACE staff as necessary.
- Non-clinical areas
  - The PACE PQIC has oversight to all activities offered by PACE.
  - Member ~~G~~grievances will be forwarded to the QI~~A~~ Coordinator and QI Manager for tracking, trending and data gathering. ~~-~~These results will be forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. ~~-~~Participants and caregivers will be informed of decisions and will be assisted with furtherment of the process as needed.~~-~~ Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
  - Member a~~A~~ppeals will be forwarded to the QI~~A~~ Coordinator and QI Manager for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. ~~If the PACE Director determines that the appeal is for clinical services, it will be forwarded to the PACE Medical Director for review. If the PACE Directorcor or PACE Medical Director disagrees with decision made by the IDT, they will approve the service and communicate this decision to IDT. If the PACE Director or PACE Medical Director agees with IDT's decision, T~~the case will then be ~~forwared~~forwarded to a third party with the appropriate licensure for review. ~~-~~The third~~-~~party reviewer's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately shared with the ~~Interdisciplinary Team~~IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.

- Transportation services will continue to be monitored through monthly metrics and ~~,~~ grievance trending. ~~, and a transportation incident log.~~ The monthly report generated by the transportation vendor will be ~~reviewed~~reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. ~~-~~The PACE QI department will validate the transportation data by periodically comparing the raw GPS data and unannounced ride along data against the reports submitted~~-~~.
- Meal quality will be monitored through daily checks of food temperatures as well as comments solicited by the CalOptima ~~PACE Member Advisory Committee~~PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.
- ~~o~~ Plans of correction on problems noted will be implemented by center staff, ~~and~~ reviewed by the PACE Program Director, PACE Medical Director or the PACE ~~QA~~ QI Manager, and ~~will be~~ presented to the PQIC.
-

~~o~~ The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

-

Priority setting for performance improvement initiatives is based on:

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver~~,~~ or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume~~,~~ or high frequency events.
- Relevance to the mission and values of CalOptima PACE.

External ~~M~~monitoring and ~~R~~reporting

CalOptima PACE will report both aggregate and individual-level data to CMS and ~~State Administering Agencies~~SAA to allow them to monitor CalOptima's PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events) ~~Level One and Level Two Reporting~~, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. ~~-~~Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of ~~the Health Plan Management System (~~HPMS~~)~~. ~~-~~The following data is ~~Level One events are~~ reported to CMS via the ~~Health Plan Management System (~~HPMS~~)~~ on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents~~Burns~~
- Medication Errors
- Immunizations
- Enrollment Data~~/Disenrollment~~
- Denials of Prospective Enrollees
- ~~•~~ Falls without Injury

-
- ER Visits~~Kennedy Terminal Ulcer~~
-

Unusual q~~Q~~uality ~~I~~incidents:~~Level Two Reporting Indicators~~

- When unusual incidents reach specified thresholds, CalOptima PACE must notify CMS on a quarterly basis through ~~the Health Plan Management System (~~HPMS~~)~~. ~~-~~ CalOptima PACE must ~~and the State Administering Agency in the required timetables,~~ complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and DHCS ~~agencies~~ as well as internally at the PACE QIC. ~~-~~The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:~~Level Two Events are:~~
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame.
    - Pressure ~~ulcer~~ injuries acquired while enrolled in the PACE Program.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
    - Any elopement.
    - Adverse ~~D~~drug ~~R~~reactions
    - Foodborne o~~O~~utbreak
    - Burns 2nd ~~D~~degree or higher
- Health Outcomes Survey-Modified (HOS-M)
    - CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other ~~E~~external ~~R~~reporting ~~R~~requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC).

Corrective ~~A~~action ~~P~~plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each ~~corrective plan~~CAP will include an explanation of the problem, the individual who is responsible for implementing the ~~corrective plan~~CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- ~~Corrective Action Plans~~CAPs from contracted providers will be requested by the QI~~A~~ Manager or ~~other~~another member of the PQIC, as appropriate.

Urgent ~~C~~corrective ~~M~~measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the CalOptima PACE Medical Director and the CalOptima PACE Director.
- The QI~~A~~ Manager or QI~~A~~ Coordinator will consult with relevant CalOptima PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

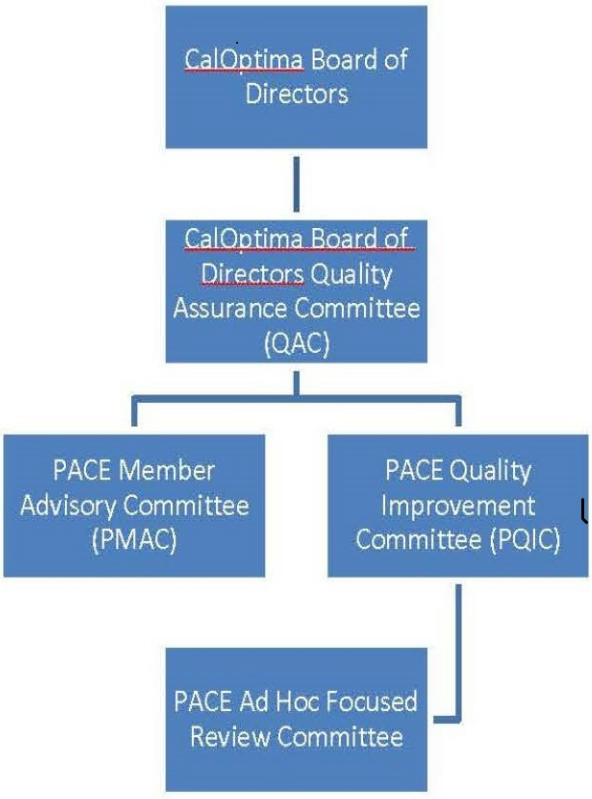
Re-~~E~~evaluation and ~~F~~follow-up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - ~~-~~Feasibility of implementation
    -
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. ~~-~~A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Annual ~~R~~review of PACE QAPI Plan

- The PACE QAPI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QAPI Work Plan.
- The CalOptima Board of Directors will review~~, revise~~ and approve the CalOptima PACE QAPI Plan, and direct the PACE Medical Director to make revisions to the QAPI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

Appendix A: 2019~~8~~ CalOptima PACE QAPI Program Reporting Structure



Appendix B

Proposed 2019 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan								
QAPI Item#	**Goal**	**Description**	**Objective**	**Sub-Objective**	**Activity**	**Reporting Frequency**	**Target completion**	**Responsible Person**
QAPI19.01	**Improve the Quality of Care for Participants**	**2018 PACE QAPI Plan and Work Plan Annual Evaluation**	2018 PACE QAPI Plan will be evaluated by March 1st, 2019	N/A	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2019	PACE Medical Director
QAPI19.02	**Improve the Quality of Care for Participants**	**2019 PACE QAPI Plan and Work Plan Annual Oversight**	PACE QAPI Plan and Work Plan will be reviewed and updated by March 1st, 2019	N/A	QAPI and QAPI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2019	PACE Medical Director
QAPI19.03	**Improve the Quality of Care for Participants**	**Influenza Immunization Rates**	>/= 90% of eligible participants will have their annual influenza vaccination by December 31st, 2019	N/A	Improve compliance with influenza immunization recommendations	Quarterly	12/31/2019	PACE Clinical Operations Manager
QAPI19.04	**Improve the Quality of Care for Participants**	**Pneumococcal Immunization Rates**	>/= 90% of eligible participants will have had their pneumococcal vaccination by December 31st, 2019	N/A	Improve compliance with pneumococcal immunization recommendations.	Quarterly	12/31/2019	PACE Clinical Operations Manager
QAPI19.05	**Improve the Quality of Care for Participants**	**Infection Control**	In 2019, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	N/A	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2019	PACE Clinical Operations Manager
QAPI19.06	**Improve the Quality of Care for Participants**	**Care for Older Adults (COA): Advance Directive Planning**	>/=95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2019	N/A	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2019	PACE Center Manager
QAPI9.07	**Improve the Quality of Care for Participants**	**Care for Older Adults (COA): Advance Directive Planning**	>/=90% of participants who a completed POLST will have the designated family member who will make decisions in emergency situations identified and documented on the POLST by December 31st, 2019	N/A	Increase the number of PACE participants who have a designated emergency, family decision maker documented on the POLST.	Quarterly	12/31/2019	PACE Center Manager
QAPI19.08	**Improve the Quality of Care for Participants**	**Care for Older Adults (COA): Functional Status Assessment**	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	N/A	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months.	Quarterly	12/31/2019	PACE Center Manager
QAPI19.09	**Improve the Quality of Care for Participants**	**Comprehensive Diabetes Care (CDC)**	100% of CDC Sub Objectives will be met in 2019	>80.12% of Diabetics will have a Blood Pressure of <140/90 (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director
				> 83.54% of Diabetics will have an Annual Eye Exam (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)		Quarterly	12/31/2019	
				>98.38% of Diabetics will have Nephropathy Monitoring (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)		Quarterly	12/31/2019	
QAPI19.10	**Ensure the Safety of Clinical Care**	**Reduce the Rate of Day Center Falls**	Decrease the rate of participate falls occurring at the PACE day centers (ACS and Garden Grove PACE) by 10% (<6.65 Falls per 1000 member months) in 2019	N/A	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2019	PACE Center Manager
QAPI19.11	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents**	<36.13% (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	N/A	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director
QAPI19.12	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs**	<3.85% (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	N/A	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director
QAPI19.13	**Ensure the Safety of Clinical Care**	**Decrease the Use of Opioids at High Dosage (UOD)**	100% of members receiving opioids for 15 or more days at an average milligram morphine dose (MME) 120mg will be reevaluated monthly by their treating provider in 2019	N/A	The PACE QI Department will monitor any participant who is receiving prescription opioids for >/= 15 days at an average milligram morphine dose (MME) >120mg	Quarterly	12/31/2019	PACE Clinical Medical Director
QAPI19.14	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	>/=90% of participants will have their medications reconciled within 30 days of hospital discharge in 2019	N/A	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2019	PACE Pharmacist

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QAPI Item#	Goal	Description	Objective	Sub-Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QAPI19.15	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	>/= 80% of specialty care authorizations will be scheduled within 10 days in 2019	N/A	Appointments for specialty care will be scheduled within 10 days to improve access to specialty care for initial consultations	Quarterly	12/31/2019	PACE Clinical Operations Manager
QAPI19.16	**Ensure Appropriate Use of Resources**	**Reduce Acute Hospital Day Utilization**	< 2,760 hospital days per 1000 per year (10% decrease from 2018)	N/A	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Medical Director
QAPI19.17	**Ensure Appropriate Use of Resources**	**Reduce Emergency Room Utilization**	< 878 emergency room visits per 1000 per year (10% decrease from 2018)	N/A	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Medical Director
QAPI19.18	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<15% 30-day all cause readmission (July 2018 CalPACE average)	N/A	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2019	PACE Medical Director
QAPI19.19	**Ensure Appropriate Use of Resources**	**Long Term Care Placement**	<3% of members (July 2018 CalPACE average) will reside in long term care	N/A	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Center Manager
QAPI19.20	**Improve Participant Experience**	**Enrollments/Disenrollments**	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment in 2019 by 10% (<27 disenrollments/K/Y)	N/A	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2019	PACE Marketing and Enrollment Manager
QAPI19.21	**Improve Participant Experience**	**Enrollments/Disenrollments**	Increase the Inquiry to enrollment conversion rate to 7% in 2019 (Baseline of 5% in the last 6 months of 2018)	N/A	Review and analyze the inquiry to enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2019	PACE Marketing and Enrollment Manager
QAPI19.22	**Improve Participant Experience**	**Transportation**	I00% of transportation trips will be less than 60 minutes in 2019	N/A	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2019	PACE Center Manager
QAPI19.23	**Improve Participant Experience**	**Transportation**	>/= 90% of all transportation rides will be on-time in 2019	N/A	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports by sampling GPS records and monthly ride-along	Quarterly	12/31/2019	PACE Center Manager
QAPI19.24	**Improve Participant Experience**	**Increase Participant Satisfaction with Meals**	>/= 64% on Satisfaction with Meals summary score (2018 CalPACE average) on the 2019 PACE Satisfaction Survey	N/A	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2019	PACE Center Manager
QAPI19.25	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	>/=88% on the Overall Satisfaction Weighted Average (2018 CalPACE Average) on the 2019 PACE Satisfaction Survey	N/A	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2019	PACE Director

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Appendix C: PACE QAPI Committee Meeting Minutes Template

PACE Quality Improvement Committee Meeting Minutes Date Time: Place: PACE conference Room 109		
Meeting Attendees: PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QA Coordinator, and the PACE Intake/Enrollment Manager.		
Meeting Notes Taker: QA Coordinator		
Topic	Presentation/Discussion	Recommendation/Action
Roll Call and Introduction		
Review and Approval of Last PQIC Meeting Minutes		
Old Business:		
New Business:		
Level II Issues		
HPMS Data Analysis		
Standing Agenda Item		
Clinical Logs and Updates		
Operational Logs and Updates		
Site Logs and Updates		
PMAC Update Report		

2019 PACE Quality Assurance Performance Improvement (QAPI) Plan

Board of Directors' Quality Assurance Committee Meeting

February 20, 2019

Miles Masatsugu, MD

Medical Director

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2019 Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations

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2018 PACE QAPI Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience

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2019 QAPI New/Updated Work Plan Elements

- Comprehensive Diabetes Care (CDC) Bundled
  - Annual Diabetic Eye Exams
  - Nephropathy Monitoring
  - Blood Pressure Control (<140/90)
- Use of Opioids at High Dosage (UOD)
- Reduce the Rate of Day Center Falls
- Increase Participant Satisfaction with Meals
- Care for Older Adults (COA): Advanced Care Planning
- Increase Inquiry to Enrollment Conversion

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Recommended Action

- Recommend approval of the 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment Performance Improvement (QAPI) Plan

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 20, 2019
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

8. Consider Recommending that the Board of Directors Extend and Authorize Allocations/Reallocations of Spending Rate Year 2010–11 Intergovernmental Transfer (IGT 1) Funds

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality & Population Health Management, (714) 246-8400

Recommended Actions

1. Authorize extension of the timeline for previously-approved spending of Rate Year 2010–11 Intergovernmental Transfer (IGT) 1 Funds to expand the child and adolescent component of the Shape Your Life (SYL) weight management program for CalOptima Medi-Cal members until the funds have been exhausted; and
2. Authorize the funds allocated for member interventions ($150,000) to support program awareness and outreach efforts, continued costs for program expansion, and the Department of Health Care Services (DHCS)-approved member and provider incentive program.

Background

In the United States, the percentage of children and adolescents affected by obesity has more than tripled since the 1970s. Data from 2015-2016 show that nearly 1 in 5 school age children and young people (6 to 19 years) in the United States has obesity. Childhood obesity has immediate and long-term effects on physical, social, and emotional health. Children with obesity are at a higher risk of having other chronic health conditions and diseases (ex. asthma, sleep apnea, type 2 diabetes, etc.) that influence physical health. Children with obesity are bullied and teased more than their normal weight peers and are more likely to suffer from social isolation, depression, and lower self-esteem. The California Department for Public Health Advocacy reports 38 percent of fifth, seventh, and ninth-graders in California are overweight or obese, compared to 33 percent in 2014. The cities with the highest levels of overweight youth are Anaheim (43.5percent), Santa Ana (46.5percent) and Stanton (51.8percent) cities which also have the highest rates of poverty, according to publichealthacvocacy.org.

CalOptima has been participating in the Intergovernmental Transfer (IGT) funds program since July 1, 2010. Each IGT must meet federal and state requirements and each transaction is approved in advance by the Department of Health Care Services (DHCS) and the Center for Medicare and Medicaid Services (CMS). Funds are potentially non-recurring, since there is no guarantee of future IGT agreements; funds are suited for one-time investments or as seed capital for new initiatives for members. Revenue must be used to finance improvements in services for Medi-Cal beneficiaries. The Health Education and Disease Management (HE/DM) department received $500,000f from IGT 1 for the purpose of creating programs for high risk children. These funds were received in fiscal year 12-13; however, the department did not obtain board approval to act on these funds until October 6, 2016.

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After a lengthy Request for Proposal (RFP), the department identified vendor support for expansion efforts and contracts were awarded in the fourth quarter of 2017.

Discussion

In 2014, staff completed a comprehensive evaluation of CalOptima's SYL program and identified many opportunities for improvement, including revising the program's structured weight management interventions for children due to the interventions' high costs, low member penetration and limited geographical access. As a result, staff redesigned the child and adolescent evidenced-based core curriculum for our community, group-based weight management interventions, refined risk stratification and rebranded our entire obesity program "Shape Your Life." The program currently provides health education materials to all its members and has outreached to all CalOptima primary care providers (PCPs) to share the evidenced-based treatment recommendations, as well as tools to aid in the office-based treatment of childhood and adult obesity.

In support of staff efforts, the Board allocated $500,000 of IGT 1 Funds for high risk children programs at its March 6, 2014, meeting. Of these allocated funds, approximately $250K have been expended to date on staffing and member/provider incentives; however, because health education group classes are a covered Medi-Cal benefit, these are not an appropriate use for IGT funds (i.e., IGT 2010-11 IGT dollars must be spent to provide enhanced benefits for existing Medi-Cal beneficiaries, not for Medi-Cal covered benefits). For this reason, staff proposes to use the $150,000 allocated for member interventions to expand awareness of the SYL program and set up costs to continue county wide expansion efforts until funds are exhausted.

Program / Awareness and Outreach Efforts:

In the first six months of program implementation in 2018, SYL classes were expanded to 10 sites throughout the county through community partnership. Approximately 850 members enrolled in classes, and 66% either reduced or maintained their BMI. CalOptima paid $25,000 in member/provider incentives during this time period.

To further expand awareness of the SYL program considering these favorable 2018 results, CalOptima staff seeks to strengthen its member communication strategies through public broadcasting television (PBS KIDS SOCAL). According to Nielsen NPOWER data sources, in the16-17 season, PBS Kids was available in 95% of U.S. households, providing kids access to what may be their only source of educational TV. The report also indicates PBS also reaches more children ages 2-8 from low-income families than any children's cable network. CalOptima would like to expand program awareness with messaging that will:

- Deliver useful health promotion and prevention messaging, specifically on the topic of healthy eating and physical fitness
- Promote healthy behaviors among members (e.g. annual physician visits, immunization calendar and flu awareness)
- Grow awareness of CalOptima brand and programs
- Improve clinical care outcomes

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Incentives:
Continue with DHCS-approved incentive program to members and providers. CalOptima incentive program is as follows:
Member

- Complete 6 group classes
- Attend a follow-up visit with their PCP
- $50 gift card for post-program office visit

Provider

- Provider follow-up appointment with member
- Complete incentive form
  - ICD-10 codes – Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) highly encouraged
- $75 for post-program office visit and reassessment (paid quarterly).

Program Administrative Costs:
Continue to support program expansion expenses including:

- Distribution of Shape Your Life newsletter
- Expand community partnership to cover more geographic areas based on member needs
- Support licensing costs to expand curriculum to additional sites
- Provide teaching aids to support improved member outcomes (food models, fitness technology products, etc.)

Fiscal Impact
The recommended action to approve the allocation of $150,000 from IGT 1 to support program marketing outreach efforts, continued costs for program expansion, and the DHCS approved member and provider incentive program has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation
Childhood obesity is a growing epidemic that affects more than 48,000 children enrolled in CalOptima's Medi-Cal program. Although health plans are not the only stakeholder in this national epidemic, CalOptima recognizes that it plays a critical role in combating this important issue.

SYL program components address environmental and cultural practices that support healthier eating and increased daily activity. These interventions can assist children in achieving and maintaining appropriate BMI levels, and prevent complications such as hyperlipidemia, hypertension, diabetes, and other chronic conditions associated with obesity. The extension of IGT funds is recommended to continue program implementation and expansion countywide. A comprehensive evaluation will be conducted 16-24 months post program implementation. This evaluation will inform long-term program components and costs for future operating budgets.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Shape Your Life Program Update – Executive Summary
2. Power Point Presentation, Shape Your Life
3. Board Action dated October 6, 2016, Consider Authorization to Expend Intergovernmental Transfer (IGT) 1 Funds to Expand the Child and Adolescent Components of the Shape Your Life Weight Management Program for CalOptima Medi-Cal Members and Contracts with Vendor(s) to Provide Weight Management Program Interventions
4. Board Action dated March 6, 2014, Approve Final Expenditure Plan for Use of FY 2010–11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011–12 IGT Funds; Authorize the Chief Executive Officer to Initiate Required Process for FY 2012–13 IGT Funds and Execute the Standard Required Application Documents

/s/ Michael Schrader — *2/14/2019*

Authorized Signature — **Date**

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Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Shape Your Life Program Update – Executive Summary

Shape Your Life Intergovernmental Transfer (IGT) Status Update:

- Completed a comprehensive assessment of our obesity program
- Redesigned our entire obesity program
  - Rebranded the program "Shape Your Life"
  - Refined our obesity risk stratification
  - Developed an evidenced-based core curriculum for our obesity interventions
  - Interactive nutrition education, physical activity and parent seminars
  - Family-centered teaching
  - Refined our evidence-based outcome metrics for our obesity interventions
  - Includes member and provider incentives for program completion
- Expansion
  - Group classes are available in seven cities throughout the county
- Shape Your Life Program Eligibility
  - Ages 5–18
  - BMI ≥85th percentile
  - Medi-Cal eligible
- Shape Your Life has received over 845 incoming program referrals.
  - Sixty-six percent of members have reduced their BMI
  - Fifty-three percent of referred members have attended at least one group class
  - Only 15 percent of referred members have refused services or dropped
  - One hundred-member incentives processed
- Program Opportunities
  - Maintain consistent messaging to members
  - Continue to expand access
  - Identify program sites that promote a positive family-based learning environment
  - Improved oversight of vendor program materials
- Proposed Next Steps
  - Request extension of the timeline for previously approved spending of Rate Year 2010-11 IGT 1 Funds to continue expansion for SYL until funds are exhausted
  - Request the use of remaining funds (approximately $250K) to support program outreach efforts, continued costs for program expansion, and the DHCS approved member and provider incentive program.
  - Consider the challenges of leveraging IGT funding to sustain the Shape Your Life Program, staff plans to transition the program operations, interventions, and incentives through the 2019 -20 budgeting process.

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Shape Your Life Update

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Pshyra Jones
Director, Health Education and Disease Management

Back to Agenda

Shape Your Life (SYL) Overview

- Program Eligibility Requirements
  - Ages 5–18
  - BMI ≥ 85th percentile
  - Medi-Cal eligible
- Program Design
  - Group classes
  - Nutrition education
  - Physical activity component
  - Family-centered (parent or close family member encouraged to participate in each class)
  - Up to 12 group classes per year

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SYL Program Goals

- Program Goals
  - Increase youth member access to weight management program(s)
  - Increase doctor-patient relationships regarding healthy weight and nutrition and physical activity counseling
  - Increase member nutrition and physical activity knowledge and behaviors.

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Evaluation

- Program Performance Measures/Evaluation
  - Pre/post BMI
  - Pre/post survey
  - Member feedback
  - Number of member incentive forms received
  - Monitor WCC HEDIS rates

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SYL Services

- SYL Providers
  - Latino Health Access
  - Dr. Riba's Health Club
  - CalOptima hosts classes at community sites
- Locations
  - Expanded to nine sites
  - Anticipate additional sites will be added

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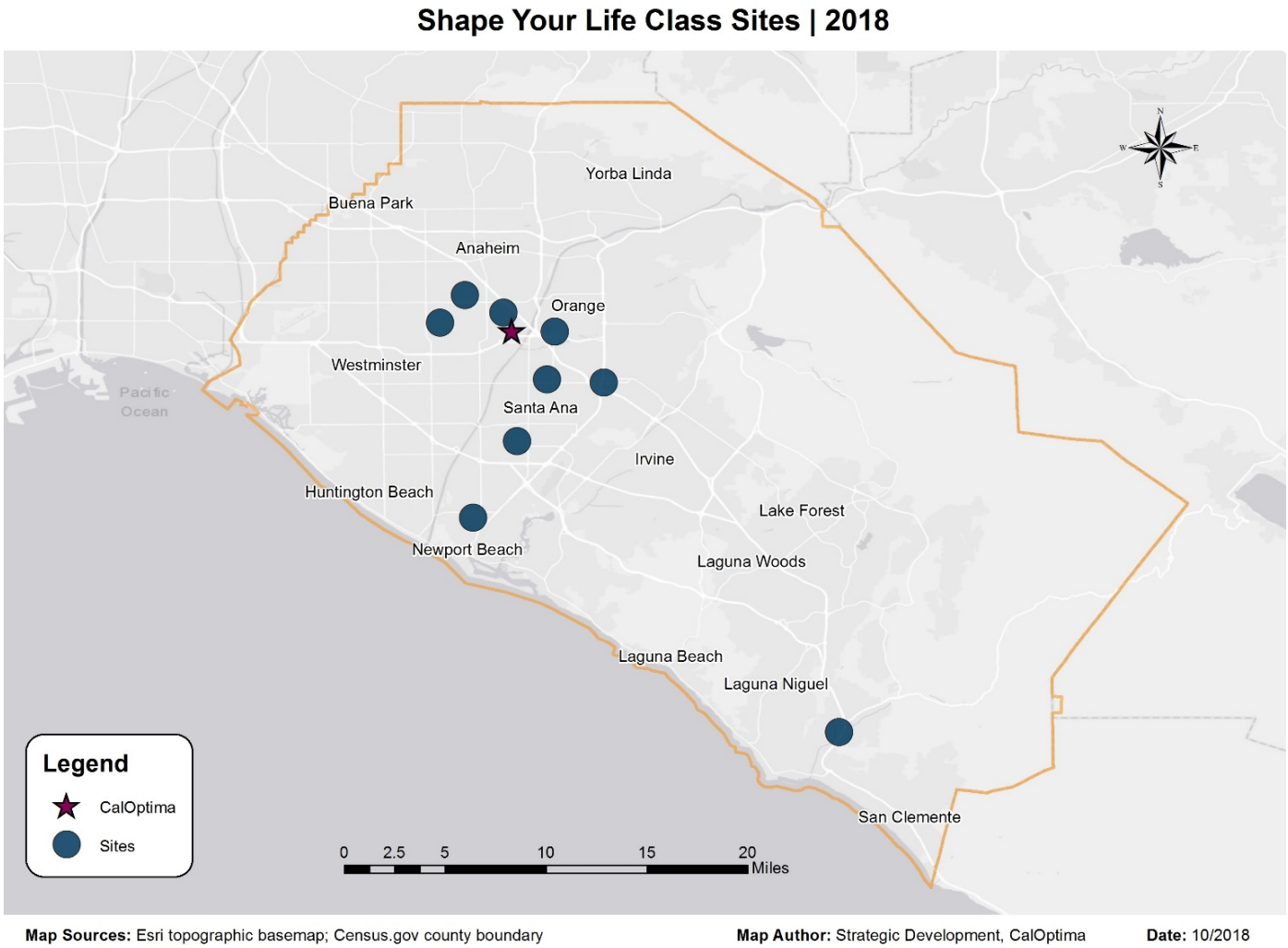
Site Map Locations



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Curriculums

- CalOptima licensed the Kids N Fitness (KNF) curriculum through Children's Hospital Los Angeles
  - Evidence-based program
  - Interactive nutrition education, physical activity and parent seminars
  - Family-centered
- Contract vendors are required to follow specific educational components including:
  - Nutrition education – MyPlate/Food Groups, Portion Control, Food Label Reading, Real vs. Processed Foods, Special Occasions and Dining Out, Healthy Fats, Fiber, Sugar and a market tour, if applicable.
  - Physical activity each class

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Incentives

- Member
  - Complete six group classes
  - Attend a follow-up visit with their PCP
  - $50 gift card
- Provider
  - Provide follow-up appointment with member
  - Completed incentive form
    - ICD-10 codes — Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) highly encouraged
  - Establish and maintain doctor-patient relationship around healthy weight
  - $75 paid quarterly

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Progress to Date

- 848 Referrals
  - 66 percent of members have reduced their BMI
  - 53 percent of referred members have attended at least one group class
  - Only 15 percent of referred members have refused service or dropped
- 100 member incentives processed
- 44 unique provider incentives

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Member Feedback

"We prefer the group setting because we feel less alone."

"We especially like how information is shared with the whole family."

"I (parent) am happy with the classes and like that I can always ask questions and see my daughters are more motivated to eat healthy."

Mother said "I like that my daughter likes the physical activity portion of the class."

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Future Program Opportunities

- Ensuring CalOptima, vendors and PCPs provide consistent messaging to members
- Expand access
- Program sites that promote a positive family-based learning environment
- Improved oversight of vendor program materials

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Shape Your Life IGT Status Update

- Completed a comprehensive assessment of our obesity program
- Redesigned our entire obesity program
  - Rebranded the program “Shape Your Life”
  - Refined our obesity risk stratification
  - Developed an evidenced-based core curriculum for our obesity interventions
  - Refined our evidence-based outcome metrics for our obesity interventions
- Expansion
  - Group classes available in seven cities throughout the county

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Proposed Next Steps

- Request Board authorization for the following:
  - Authorize extension of the timeline for previously approved spending of Rate Year 2010–11 Intergovernmental Transfer (IGT) 1 Funds to expand the child and adolescent component of the Shape Your Life (SYL) weight management program for CalOptima Medi-Cal members until funds have been exhausted; and
  - Authorize the funds allocated for member interventions ($150,000) to support program awareness and outreach efforts, continued costs for program expansion, and the Department of Health Care Services (DHCS) approved member and provider incentive program.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken October 6, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Consider Authorization to Expend Intergovernmental Transfer (IGT) 1 Funds to Expand the Child and Adolescent Components of the Shape Your Life Weight Management Program for CalOptima Medi-Cal Members and Contracts with Vendor(s) to Provide Weight Management Program Interventions

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400

Recommended Actions

Authorize:

1. The expenditure of $500,000 in Intergovernmental Transfer (IGT) 1 funds to expand the child and adolescent component of the Shape Your Life weight management program for CalOptima Medi-Cal members, which includes, subject to regulatory approval as applicable, member and provider incentives; and
2. The Chief Executive Officer to contract with the vendor(s) selected through an RFP process to provide group-based child and adolescent Shape Your Life program interventions.

Background

Childhood obesity is a growing national epidemic that has more than doubled in children and quadrupled in adolescents in the past 30 years. Overweight and obesity in childhood are known to have significant impact on both physical and psychosocial heath. In 2014, an average of 33% of Orange County students in 5th, 7th, and 9th grades were overweight or obese, compared to 38% statewide. In 2011-2012, 32% of Orange County adults were overweight, in addition to23% identified as obese. Weight status has worsened in Orange County, decreasing from 50% of adults with a healthy weight in 2001 to only 43% in 2011-2012.

Discussion

CalOptima's takes a population management approach towards addressing obesity. Clinical practice guidelines serve as the foundation of the program. These guidelines provide direction for medically-based prevention and treatment protocols within the program. The child and adolescent component of the Shape Your Life program has adopted the clinical practice guidelines entitled "Prevention, Assessment and Treatment of Childhood Obesity: Recommendations from the AMA Expert Committee on Childhood Obesity, June 2007". The main tenet of these guidelines is that a staged approach should be used in the treatment of childhood obesity. This incremental approach begins with health education and moves to structured weight management programs.

Staff has completed a comprehensive evaluation of CalOptima's program and identified many opportunities for improvement, including revising the program's structured weight management interventions for children due to the interventions' high costs, low member penetration and limited geographical access. As a result, staff has redesigned the child and adolescent evidenced-based core

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curriculum for our community, group-based weight management interventions, refined our risk stratification and rebranded our entire obesity program "Shape Your Life." The program currently provides health education materials to all its members and has outreached to all CalOptima primary care physicians (PCPs) to share the evidenced-based treatment recommendations, as well as tools to aid in the office-based treatment of childhood and adult obesity.

The Board allocated $500,000 of IGT 1 funds for high risk children programs at its March 6, 2014, meeting. Of these allocated funds, none have been expended to date. Staff believes these funds are best used to expand the child and adolescent components of the redesigned Shape Your Life program.

Staff proposes to use $150,000 on the group-based weight management childhood obesity interventions, $100,000 for member and provider incentives and up to $250,000 over two years to hire new staff to manage this expansion.

Child and Adolescent Group-Based Interventions: $150,000
For the proposed child and adolescent group-based weight management interventions, staff plans to use the RFP process to find and contract with vendors who can provide these services countywide to our child and adolescent Medi-Cal members. The proposed intervention will be 6-8 group-based visits with nutritional, exercise and healthy habit components.

Incentives: $100,000
A proposed distribution approach for the member and provider incentives are presented below. However, actual payment and methodology will be finalized based on funds available, DHCS approval of member incentive plan and participant engagement. Member incentive goals will be established by CalOptima. The goals will be based on completing 6-8 group-based visits, completing a pre and post-program PCP assessment and behavior modification achievements as measured by a validated questionnaire. Provide incentives will be established by CalOptima and will be based on program referrals, pre-intervention program assessments and post-intervention assessments.

Member
- $50 for achievement of program process and outcome goals.
- $25 for post-program office visit.

Provider
- $25 for program referral and member assessment.
- $50 for post-program office visit and reassessment.

Staffing: $250,000
Staff proposes the use of up to $250,000 over two years to hire one new project manager that will help in the expansion of the child and adolescent components of the Shape Your Life program. As proposed, the staff duties will include:
1. Evaluating the vendors who respond to the RFP
2. Developing rates for the community, group-based child and adolescent weight management interventions

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3. Providing technical assistance to vendors across the county as needed
4. Developing, managing and evaluating the child and adolescent "Shape Your Life" member and provider incentives
5. Continuously evaluate the vendors, interventions and the incentive programs

At the conclusion of the two years, staff will transition the remaining ongoing duties of the project manager to budgeted staff positions.

Fiscal Impact

The recommended action to authorize use of $500,000 in currently available IGT 1 funds to expand CalOptima's Shape Your Life program is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Childhood obesity is a growing epidemic that affects more than 48,000 children enrolled in CalOptima's Medi-Cal program. Although health plans are not the only stakeholder in this national epidemic, CalOptima recognizes that it plays a critical role in combating this important issue.

Early intervention can assist children in achieving and maintaining appropriate BMI levels. These interventions may prevent complications such as hyperlipidemia, hypertension, diabetes, and other chronic conditions associated with obesity. The IGT funds will be used to expand the newly redesigned child and adolescent components of the CalOptima Shape Your Life program with a focus on evidence-based interventions and outcomes.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

1. Power Point Presentation, Shape Your Life Expansion
2. Board Action dated March 6, 2014, Approve Final Expenditure Plan for Use of FY 2010-11 IGT Funds; Approve Expenditure Plan for Use of FY 2011-12 IGT Funds; Authorize the CEO to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

/s/ Michael Schrader — *09/29/2016*
Authorized Signature — **Date**

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“Shape Your Life” Expansion

Board of Directors Meeting

October 6, 2016

Dr. Miles Masatsugu, Medical Director

Pshyra Jones, Director, Health Education & Disease Management

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Roadmap

- Completed a comprehensive assessment of our obesity programs
- Redesigned our entire obesity program
  - Rebranded the program “Shape Your Life”
  - Refined our obesity risk stratification
  - Developed an evidenced-based core curriculum for our obesity interventions
  - Refined our evidence-based outcome metrics for our obesity interventions
- Expansion
- Evaluation and further refinement

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Assessment Findings

- Evidence **is not yet conclusive** on the long term benefits of intensive short term interventions.
- However, evidence-based recommendations on the prevention and treatment of childhood obesity have been made and endorsed by the CDC, AAP and AMA
- Limited provider understanding of evidence-based recommendations
- Providers and members alike would like to know what resources exist in the community and what is offered through CalOptima
- Access is an issue for our members due to limited intervention sites and lack of knowledge of the interventions offered by CalOptima by both its providers and members.

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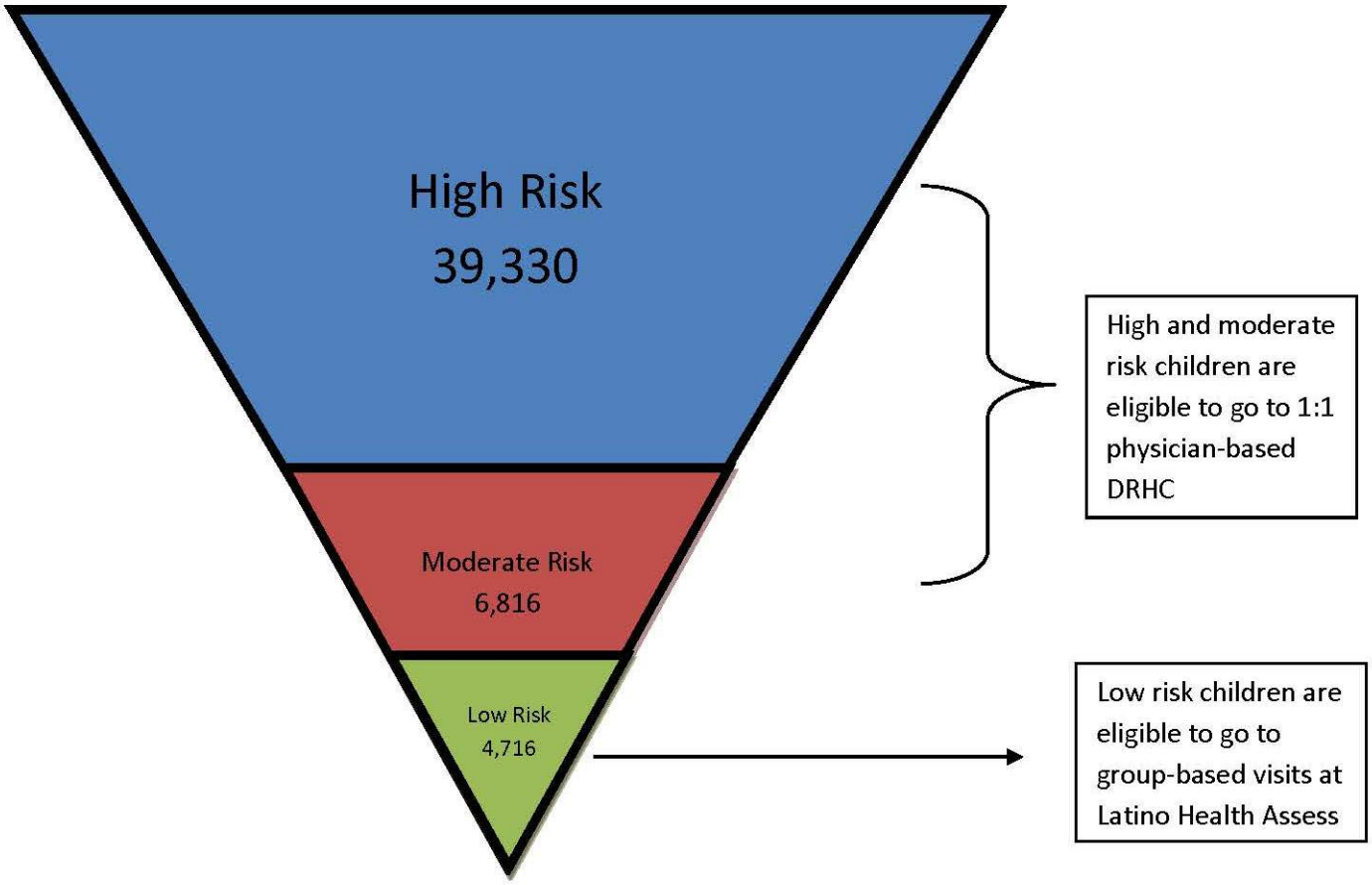
Assessment Findings: Risk Stratification Data Upside Down



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Assessment Findings: Penetration Low and Costs High

		2012-2013	2013-2014	% Increase Year Over Year
Dr. Riba's Health Club	Members	361	666	84%
Medium and High Risk	Visits	1,165	2,325	99.6%
Members	Costs	$130,020	$263,200	102.4%
	Cost per Member	$364.20	$395.13	7.8%
		2012-2013	2013-2014	% Increase
Latino Health Access	Members	100	115	15%
Low Risk	Visits	764	843	10.3%
Members	Costs	$76,472	$85,788	12.1%
	Costs per Member	$764.72	$745.98	-2.5%

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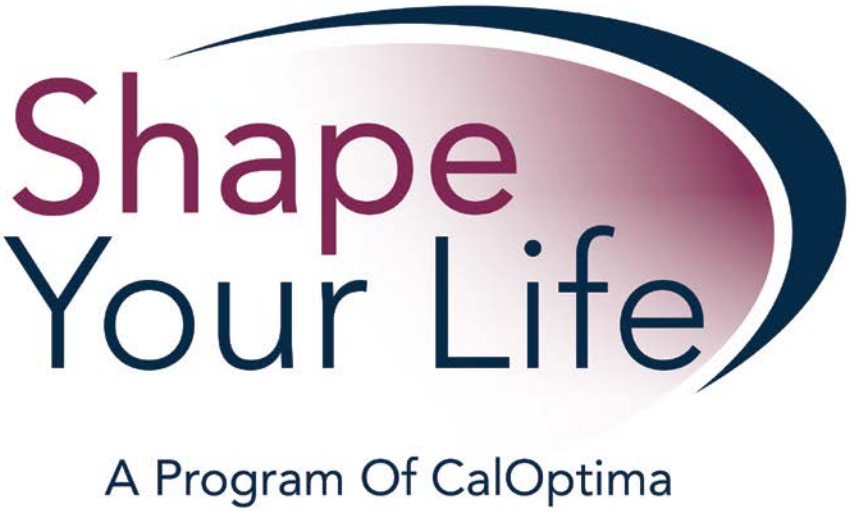
Rebranded Obesity Program



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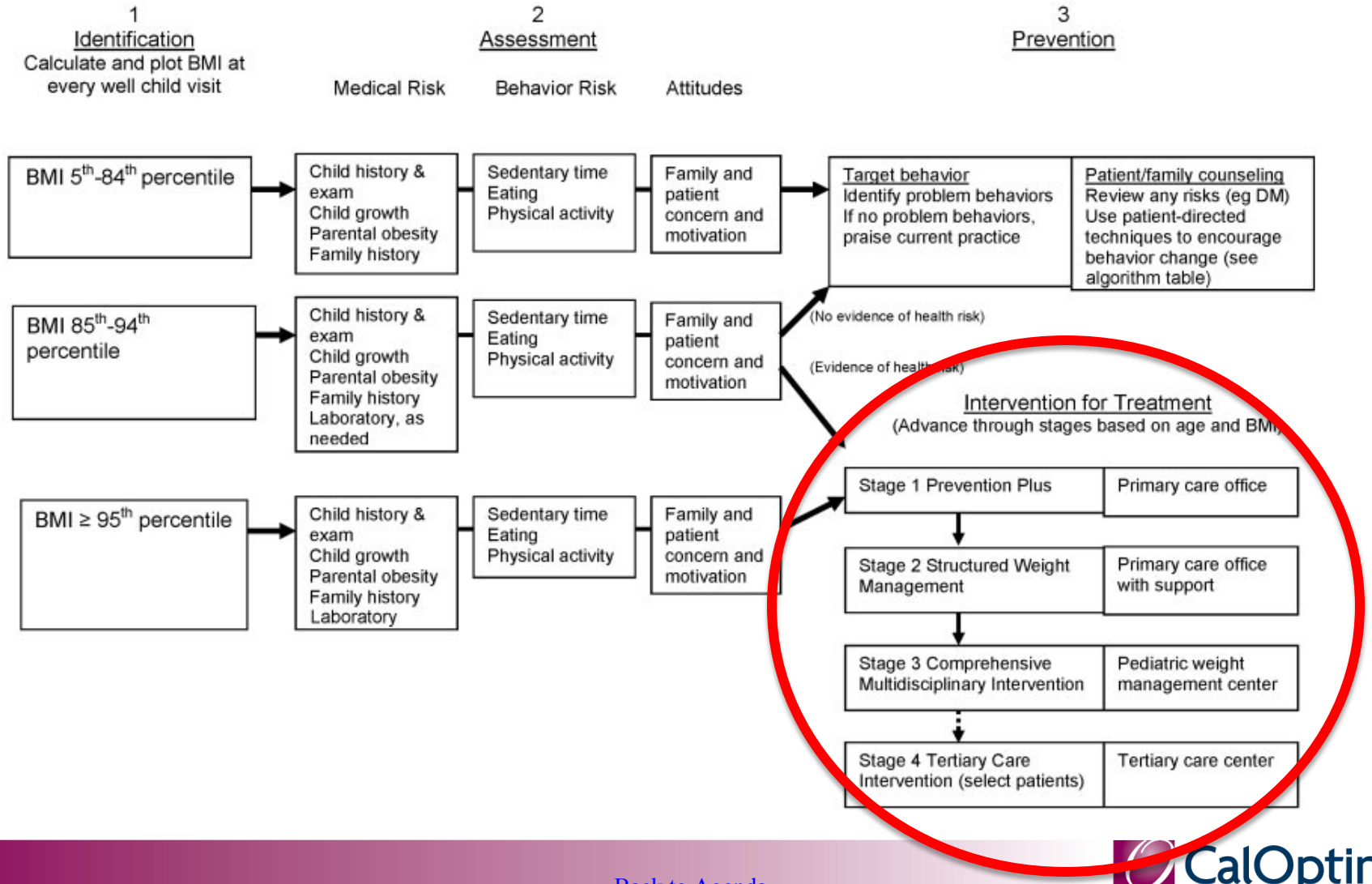
Adopted the Expert Committee Recommendations for the Assessment, Prevention, and Treatment of Childhood Obesity by Childhood Obesity Action Network (COAN) Evidenced-Based Recommendations



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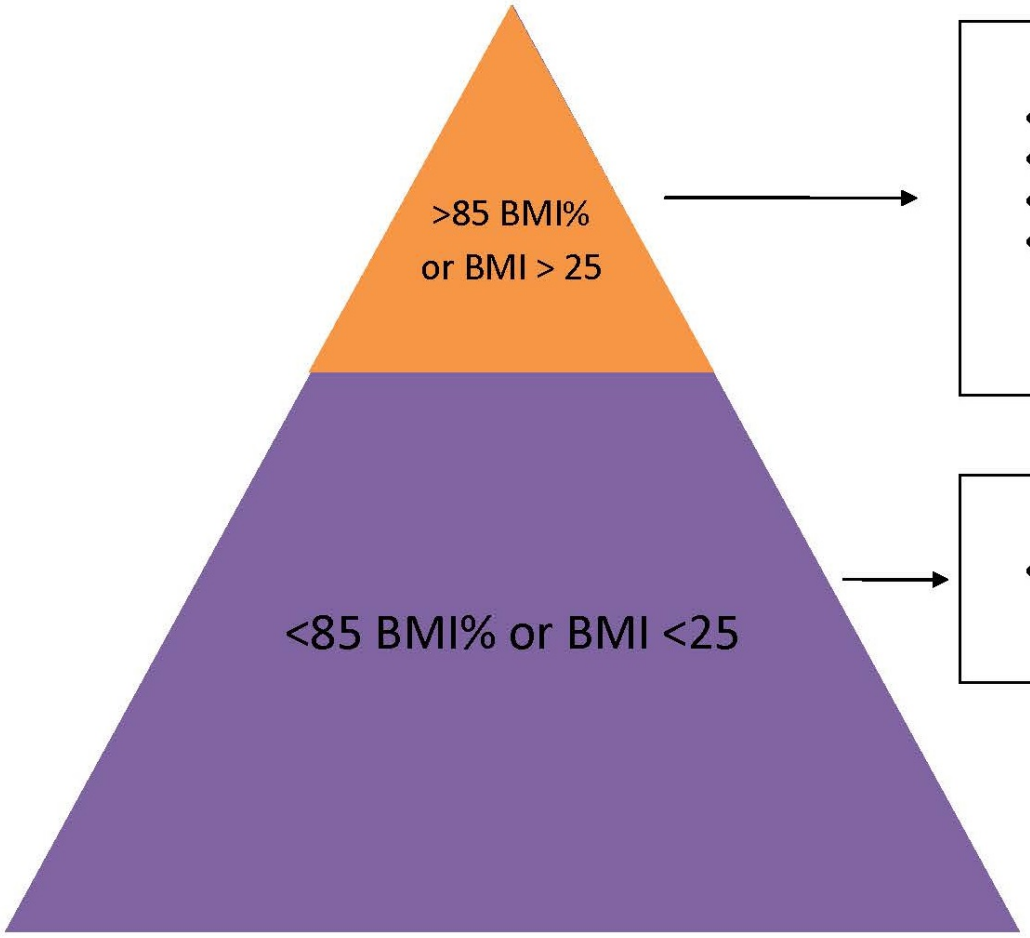
Refined New Risk Stratification



Structured Weight Management

- w/PCP
- Group-based interventions
- Member and Provider Incentives
- Telephonic counseling from CalOptima Health Education Department

Prevention

- Regular newsletters & mailed educational material

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Redesigned Interventions (Implemented)

- Entire Population
  - Healthy Alert
    - Quarterly newsletter w/healthy recipes, tips for parents, teens and children, informed about other services for eligible members
- Group-Based Interventions
  - Assessing member readiness for behavior modification prior to authorization
  - Streamlined referral process
  - Supportive tools and local resources mailed to members to support group-based education intervention model
  - Evaluated existing vendor contracts

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Redesigned Interventions (Not Implemented)

- Member incentives to improve children's participation in group-based interventions and reaching outcome goals
- Provider incentives to improve the assessments, referrals and post-program reassessments of overweight and obese children
- Expand the group-based educational intervention for children countywide

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Proposed Next Steps

- Request Board authorization to expend the $500,000 in allocated IGT funds
- Request for Proposal (RFP) to find vendors who can provide the group-based intervention
- Hire project manager
- Develop Member and Provider Incentives
- Contract with vendors and expand intervention countywide
- Ongoing evaluation of interventions and incentive programs

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Project Manager Duties

- Evaluate the vendors who respond to the RFP
- Provide technical assistance to vendors as needed
- Develop, manage and evaluate the child and adolescent “Shape Your Life” member and provider incentives
- Develop, manage and evaluate the child and adolescent “Shape Your Life” group-based interventions

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Proposed Member and Provider Incentives

Member

- $50 for achievement of program process and outcome goals*
- $25 for post-program office visit*

Provider

- $25 for program referral and member assessment*
- $50 for post-program office visit and reassessment*

*Actual payment and methodology will be finalized based on funds available, DHCS approval of member incentive plan and participation engagement

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Proposed IGT Expenditures to Expand “Shape Your Life”

- Use up to $250,000 to add a new staff member for up to two years to implement and manage the program expansion
- $100,000 to support member & provider incentives
- $150,000 to pay new vendors for group-based intervention services

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Recommended Board Action

- Recommend Board of Directors' authorize the expenditure of $500,000 in Intergovernmental Transfer (IGT) 1 funds to expand the child and adolescent component of the Shape Your Life program for CalOptima Medi-Cal members.
- Recommend authorizing the CEO to contract with the vendors selected through the RFP process to provide the group-based child and adolescent Shape Your Life program interventions.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve final expenditure plan for $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for $7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained $12.4 Million, UCI retained $8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained $7.4 million, UCI retained $4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

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Table 1. Approved Expenditure Plan for IGT 1	**Budget**
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	**Budget**
Complex Case Management • Case management for high-risk members across various care settings, including improved documentation of clinical risk	Year 1: $6.9M Year 2: $4.4M
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Proposed Expenditure Plan for IGT 2
As previously stated, CalOptima retained $7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

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1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	**Budget**
Enhancement of Core Data Systems	$3.0 M
Continuation/Expansion of IGT 1 Initiatives	$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	$1.4 M
Total Budget	**$7.4 M**

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

2/28/2014 — **Date**

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Intergovernmental Transfers (IGT)

Board of Directors Meeting
March 6, 2014

Ilia Rolon
Director, Strategic Development

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Background

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About IGTs

- Intergovernmental Transfers (IGTs) are transfers of public funds between governmental entities
- Extensive precedent of IGTs among managed care plans in California
- California managed care plans have historically saved state/federal governments millions in health care costs
  - Federal Medical Assistance Percentage (FMAP): Amount of federal match for states' expenditures on social, medical services
    - California: 50%
    - Mississipi: 73%
- IGTs are a means of leveling the field and ensuring continued investment in our healthcare systems

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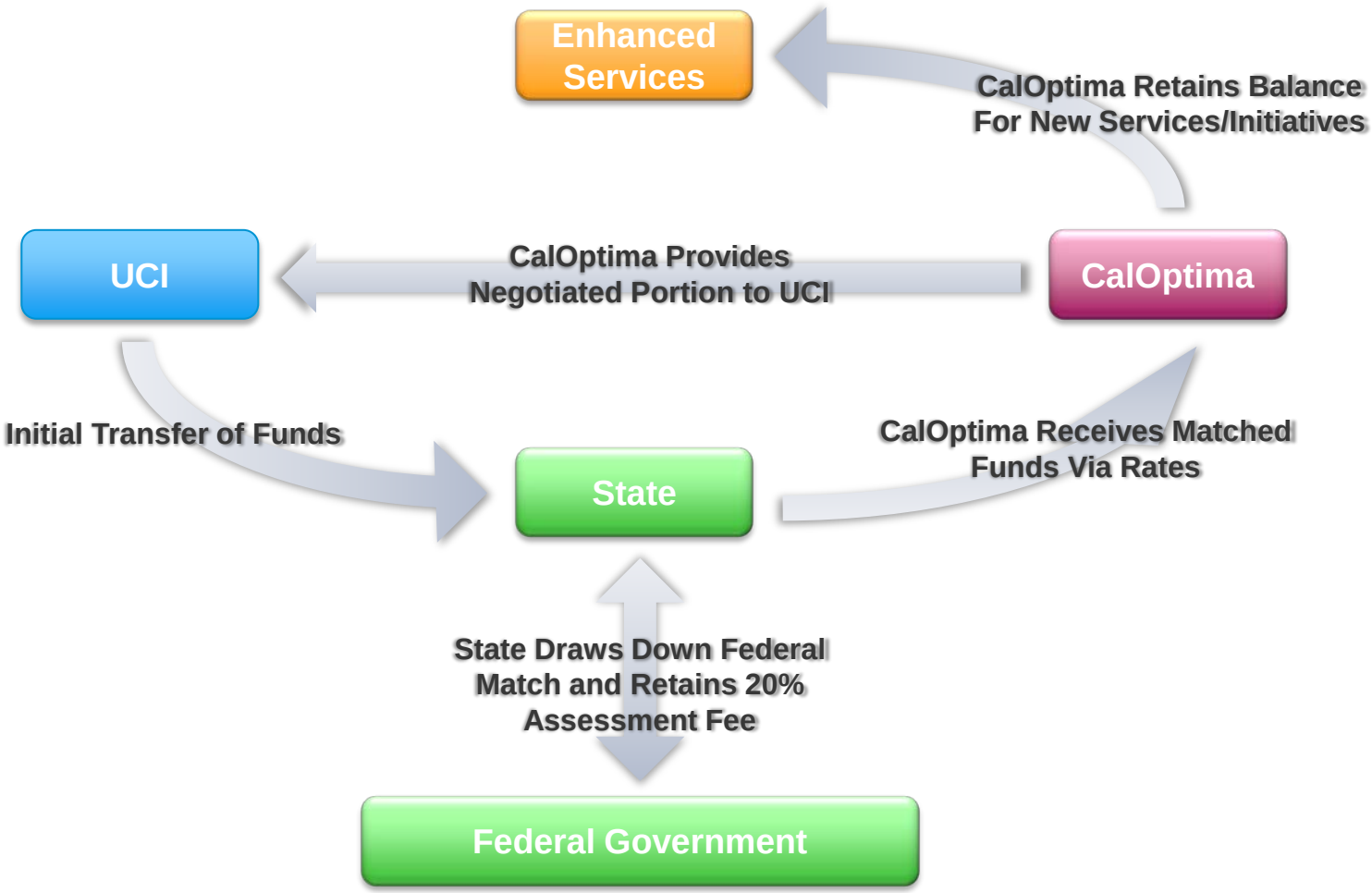
IGT Transaction Overview



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Use of Funds

- Revenue must be used to finance improvements in services for Medi-Cal beneficiaries
- No guarantee of future IGT agreements -- thus funds are best suited for one-time investments or as seed capital for new services or initiatives
- Budgeted uses for current IGTs are consistent with system improvements that will support successful response to OneCare audit
- Agreements are silent on deadline for use of funds

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IGTs Received to Date

Funding Source	Claim Year	Year Received	CalOptima Amount	UCI Amount	State Amount	Total
IGT 1	FY 10-11	2012	**$12.4 M**	**$8.4 M***	$3.1 M	$23.9 M
IGT 2	FY 11-12	2013	**$7.4 M**	**$4.8 M**	$5.4 M	$17.6 M
Total Funds			**$19.8 M**	**$13.2 M**	$8.5 M	$41.5 M

- IGT 1 included a one-year community vetting process; proposed uses for IGTs 2 and 3 are consistent with results of this earlier process
- Status of IGT Year 1 expenditures: $2 M contract award for new case management system; agreements with health networks for approximately $2 M in funding for personal care coordinators pending

* UCI's net revenue was $3.4 Million due to exclusion from approximately $5.0 million in state disproportionate share (DSH) payments

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Proposal

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IGT 1 Expenditure Plan

Proposed Uses	Year 1	Year 2	Impacted Programs	Timing	Description
Complex Case Management I	$5.1 M	$4.2 M	–	–	
Personal Care Coordinators	$1.85 M	$1.95 M	CMC	CY 14	Additional PMPM line item payment to networks
Case Management System	$2.0 M	$0	All	CY 14	Replace existing case management system
Strategies to Reduce Readmission	$1.0 M	$2.0 M	MC, CMC OneCare	CY 14	Post-discharge follow up; transitions of care
Program for High-Risk Children	$250 K	$250 K	MC	FY 14/15	Services for children affected by both obesity and asthma
Complex Case Management II	**$1.8 M**	**$200,000**	**N/A**	**N/A**	**Merge this category with CCM 1**
Access Strategies	$450,000	$650,000	–	–	
e-Referral/ Telemedicine	TBD	TBD	All	CY 14	Dermatology project in development
Total Funds	$7.35 M	$5.05 M			

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Proposed IGT 2 Expenditure Plan

CMS and CalOptima Board Approved Categories	Proposed Allocation
Enhanced Core Systems • Facets system upgrade and reconfiguration • Provider network management solution • Security audit remediation • Funding to continue COREC services for two years	**$3.0 M**
Continued / Expanded IGT 1 Services •Personal care coordinators •Strategies to reduce hospital readmissions	**$3.0 M**
Wraparound Services & Optional Benefits • To be developed further. • May include: school-based vision and dental services for children; recuperative care for homeless members discharged from hospital; and/or backfilling Medi-Cal cuts to payments and/or benefits.	**$1.4 M**
Total Funds	**$7.4 M**

60% for direct services

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Next Steps

- Execute approved expenditure plan for IGT 1
- Begin implementation of IGT 2 funded activities
- Initiate process to explore feasibility of securing third IGT
- Periodic Board updates on progress

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400

Recommended Actions

1. Approve final expenditure plan for $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for $7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained $12.4 Million, UCI retained $8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained $7.4 million, UCI retained $4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

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Table 1. Approved Expenditure Plan for IGT 1	**Budget**
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	**Budget**
Complex Case Management • Case management for high-risk members across various care settings, including improved documentation of clinical risk	Year 1: $6.9M Year 2: $4.4M
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Proposed Expenditure Plan for IGT 2
As previously stated, CalOptima retained $7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

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1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	**Budget**
Enhancement of Core Data Systems	$3.0 M
Continuation/Expansion of IGT 1 Initiatives	$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	$1.4 M
Total Budget	**$7.4 M**

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — **Authorized Signature**

2/28/2014 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 20, 2019
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

9. Consider Recommending Board of Directors' Approval of Modifications of CalOptima Policies and Procedures Related to Grievances and Appeals, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule), and Annual Policy Review

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400

Recommended Actions

Authorize modifications of CalOptima's existing Policies and Procedures for the Grievance and Appeals process to be in compliance with Regulatory requirements and Medicaid Final Rule as follows:

1. HH.1102: CalOptima Member Complaint
2. HH.1103: CalOptima Health Network Member Complaint
3. HH.1108: State Hearing Process
4. GG.1510: Appeal Process for Decisions Regarding Care and Services
5. GG.1814: Appeal Process for Long Term Care Facility

Background

Periodically, CalOptima modifies existing Policies and Procedures to implement modified laws, regulatory guidance, contracts and business practices. CalOptima has established an annual policy review process by which Policies and Procedures are updated and subject to peer review. New and modified Policy and Procedures are developed on an ad hoc basis as new laws, regulations, guidelines, or programs are established. Most recently, the following has impacted CalOptima's Policies and Procedures:

In April 2016, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register the Medicaid and CHIP Managed Care Final Rule [Medicaid Managed Care (CMS-2390-F)], which aligns key rules with those of other health insurance coverage programs, modernizes how states purchase managed care for beneficiaries, and strengthens the consumer experience and key consumer protections. This Final Rule is the first major update to the Medicaid and CHIP managed care regulations in more than a decade. These regulations are sometimes referred to in aggregate as the "Mega Reg".

The Department of Health Care Services (DHCS) has provided guidance to incorporate requirements of the Final Rule into Managed Care Plans (MCPs). On June 1, 2017, the CalOptima Board of Directors approved an amendment to CalOptima's contract with DHCS to include Final Rule requirements.

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Discussion

The following Grievance and Appeals policies have been updated and are being presented for review and approval:

1. ***HH.1102: CalOptima Member Complaint*** defines the process by which CalOptima addresses and resolves Grievances from a Member or a Member's Authorized Representative, in accordance with applicable statutory, regulatory, and contractual requirements. The title of this policy is being updated to *Member Grievanc*e based on the new delineated separation between a grievance and an appeal previously referred to as a complaint. The policy is also modified to allow a provider to file a grievance on Member's behalf with Member consent. In addition, expedited grievance requirements were added. In the event that resolution is not reached within 30 calendar days, the Member shall be notified of the status and a statement was included in the policy to state that a resolution shall not exceed 14 calendar days following a status letter on a grievance. In addition, an appeal process specific to non-coverage determinations has been added to the policy.
2. ***HH.1103: CalOptima Health Network Member Complaint*** is for applicable health network(s) and defines the process by which a Health Network shall address and resolve Grievances and Appeals for Members enrolled in a Health Network, under supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department. This title of this policy is being updated to CalOptima Health Network Member Grievance and Appeals Process to be in line with the Final Rule distinction between grievances and appeals. The policy is modified to allow a provider to file a grievance on Member's behalf with Member consent. Expedited grievance requirements were added to this policy. Included a clause that allows a Member to request a State Hearing if the Health Network fails to send a resolution notice within 30 calendar days. In addition, the previous provisions of the policy allowing for a 14-day extension to the response deadline has been removed. Last, it was added that the Health Network will process the Appeal whether a signed written confirmation is received from the Member or not.
3. ***HH.1108: State Hearing Process*** defines CalOptima's process, role and responsibilities in ensuring a Member's right to access the State Hearing process. The policy is modified to allow a provider to file a State Hearing on Member's behalf with Member consent. The State Hearing processes were divided in sections for clarity, including the expedited hearing process. The policy is also modified to include specific language about authorizing or providing the service within 72 hours if the decision is wholly or partially in favor of the Member.
4. ***GG.1510: Appeal Process for Decisions Regarding Care and Services*** defines the process by which CalOptima addresses and resolves Utilization Management (UM) appeals, including Adverse Benefit Determinations involving the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit. The title of this policy is being updated to *Appeal Process* since it includes all UM appeals. The policy is also modified to allow a provider to file an appeal on Member's behalf with Member consent. Clarification was added to this policy that the UM Appeal process is separate from a Complaint, State Hearing or Provider Complaint process. References to a 14-day extension were removed. The

policy has been updated to clarify that a Member may be represented by anyone, including a legal representative.

5. ***GG.1814: Appeals Process for Long Term Care Facility*** defines the process by which a Long-Term Care (LTC) Facility provider may Appeal a CalOptima post-service Level of Care decision to deny, modify, or recommend alternative options to a request for LTC Facility daily rate services for a Medi-Cal, or OneCare Connect Member. This policy is being submitted for annual review and approval. Only grammatical changes were made.

Fiscal Impact
The recommended action to authorize modifications to existing Grievance and Appeals policies and procedures to ensure compliance with regulatory requirements and the Medicaid Final Rule is not anticipated to have a material fiscal impact to CalOptima.

Rationale for Recommendation
To ensure that CalOptima's Grievance and Appeals policies and procedures are updated to meet the requirements of the Final Rule, approval of modifications is recommended.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Revised CalOptima Policies, redlined and clean copies:
1. HH.1102: CalOptima Member Complaint
2. HH.1103: CalOptima Health Network Member Complaint
3. HH.1108: State Hearing Process
4. GG.1510: Appeal Process for Decisions Regarding Care and Services
5. GG.1814: Appeal Process for Long Term Care Facility

/s/ Michael Schrader — *2/14/2019*
Authorized Signature — **Date**

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Policy #:	HH.1102
Title:	~~CalOptima~~ **Member** ~~Complaint~~**Grievance**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/1996
~~Last~~ Revised Date:	~~07/01/17~~TBD

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves Grievances from a Member or a Member's Authorized Representative, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall establish and maintain a Grievance Process pursuant to which a Member, or a Member's Authorized Representative~~.~~, or Provider acting on behalf of the Member and with the Member's written consent, may submit a Grievance for review and Resolution.

B. CalOptima's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

C. A Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the complaint shall still be categorized as a Grievance.

~~C.~~D. CalOptima shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs.

~~D.~~E. CalOptima shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance, or may manage a Grievance under the supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

F. CalOptima shall process expedited requests timely in instances where a Provider indicates, or CalOptima determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

~~E.~~G. CalOptima shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance~~.~~ and he or she is not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease.

~~F.~~H. CalOptima shall refer all medical quality of care issues identified through the Grievance Process to the Quality Improvement Department for review.

~~G.~~I. CalOptima shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that ~~the Member~~he or she filed a Grievance~~, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations~~.

~~H. CalOptima, a Health Network, Provider, or Practitioner shall not discriminate against a Member in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.~~

~~I.~~J. CalOptima and a Health Network shall inform a Member of their right to file a Grievance through CalOptima at any time ~~that caused the Member's~~to express dissatisfaction~~,~~ about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA), in accordance with the provisions of this policy~~.~~.

a. A Member's Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance at any time.

~~J.~~K. CalOptima and a Health Network shall inform a Member of their right to file an Appeal ~~within sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) that delayed, denied, deferred, or modified a request for services. CalOptima shall process an Appeal,~~ in accordance with CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~.

~~K.~~L. CalOptima and a Health Network shall inform a Member, during the ~~Complaint~~Grievance Process, of their right to request a State Hearing after the Appeal ~~Process~~process, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures, GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and GG.1510: Member Appeal Process ~~for Decisions Regarding Care and Services~~.

~~L.~~M. CalOptima shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. ~~In the case of a Grievance subject to an expedited review,~~ CalOptima and a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances.

~~M.~~N. CalOptima shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Records, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or the Member's Authorized Representative ~~at no cost~~, or Provider acting on behalf of the Member and with the Member's written consent. CalOptima shall provide records at no cost.

~~N.~~O. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance ~~process~~Process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

~~O.~~P. CalOptima and a Health Network shall inform a Member of their right to file a Grievance with CalOptima or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

~~P.~~Q. CalOptima shall process Exempt Grievances ~~s~~ in accordance with CalOptima Policy DD.2013: Exempt Grievance Process.

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make complaint forms and procedures for filing a Grievance available to facilities that provide Covered Services to Members.

2. CalOptima shall provide complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances, and shall triage Member calls and route Grievances to GARS via its electronic system.

B. Grievance Process

1. A Member, or a Member's Authorized Representative~~-~~, or Provider acting on behalf of the Member and with the Member's written consent, may file a Grievance:

   a. With CalOptima's Customer Service Department, by telephone, or in person; or

   b. With CalOptima GARS, by facsimile, in writing, or through the CalOptima website at www.caloptima.org.

   c. CalOptima shall provide language assistance, by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

   d. CalOptima will process the Grievance whether or not a signed written confirmation is received from the Member.

2. GARS shall:

   a. Date stamp and document the substance of the Grievance in the GARS database, verifying demographics and network affiliation.

   b. Determine the category of ~~-~~Grievance~~(~~, including but not limited to the following categories: quality of care, quality of service, access to care, and other~~)~~, based on the Grievance~~, assign~~. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

   c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution.

   d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Grievance.

   e. Refer all Grievances related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

f. Review and immediately process all Grievances ~~of an imminent and serious threat to~~ that may seriously jeopardize the Member's life or health ~~of a Member, including, but not limited to, severe pain or potential loss of life, limb,~~ or ~~major bodily~~ability to attain, maintain or regain maximum function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited ~~review~~ Grievance as required in the CalOptima contract with Department of Health Care Services (DHCS).

g. Escalate the Grievance for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Grievance.

h. Send the Member a Grievance Resolution Letter within thirty (30) calendar days after receipt of the Grievance.

i. ~~In~~For a standard Grievance, in the event the Resolution is not reached in thirty (30) days, notify the Member in writing of the status of the Grievance and provide an estimated completion date of Resolution, which shall not exceed fourteen (14) calendar days.

j. Translate Grievance ~~Resolution Letters~~correspondence into Threshold Languages, and offer oral interpretation for ~~a~~ Grievance ~~Resolution Letter~~correspondence for all other languages; and

~~j.~~k. Provide an interpreter, or auxiliary aide, for assistance in the Grievance Process.

3. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a. Summary of the Member's Grievance;

b. The investigation made in the review process, including any referrals to the Quality Improvement Department for medical quality of care review;

c. When possible, the outcome of the review;

d. Alternative resources or references, when applicable; and

e. The Member's right to Appeal, as appropriate.

6. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, reviewing entity(ies), decision and any action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member ~~end date~~ and save the electronic file.

C. Non-Coverage Appeals

1. A Member or Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS within sixty (60) calendar days of the date of the Non-Coverage Decision Resolution Letter. This type of

Grievance is considered a non-coverage appeal and is separate from the appeal process in CalOptima Policy GG.1510: Appeal Process.

2. A Member or Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may file the non-coverage appeal with CalOptima's Customer Service Department by telephone or in person; or with GARS via facsimile, in writing or through the CalOptima Website at www.caloptima.org.

3. CalOptima shall provide language assistance by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.

5. Upon receipt of the Non-Coverage Appeal GARS shall:

   a. Date stamp and document the substance of the Non-Coverage Appeal into its electronic system, verifying demographics and network affiliation;

   b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s);

   c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the non-coverage appeal;

   d. Triage and investigate the Non-Coverage Appeals and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Complaint;

   e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Chief CMO or their Designee and any action deemed necessary under the quality review process;

   f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt;

   g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance.

      i. CalOptima shall translate Grievance Resolution Letters into Threshold Languages and offer oral interpretation for a Grievance Resolution Letter, written in English, for all other languages.

      ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests to be in CalOptima Direct - Administrative, and for access to out-of-network Providers or change of Health Networks, the resolution letter shall include:

         1) Summary of the Member's Non-Coverage Appeal;

2) Description of actions taken to review the request;

3) Date and name of position of staff involved in the review;

4) Date of the issuance of the decision.

6. CalOptima shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter.

7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity (ies), decision and any action taken (if any), include a copy of the Resolution Letter and document any oral notification provided to the Member, and resolution date.

E. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Grievance Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Grievances in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

F. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, and related procedures regarding the Grievance Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Grievance, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Grievance Resolution Letters and Notice of Appeal Resolution letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. On a quarterly basis, CalOptima shall submit all recorded Member Grievances related to access to care, quality of care and denial of services to the Quality Improvement Committee (QIC) to review and take appropriate action to remedy any problems identified in such reviews.

4. CalOptima shall submit a report of aggregated Grievance data, as required, to DHCS.

5. CalOptima shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

6. CalOptima shall submit a report of Grievances related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Grievances or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Grievance was reported to the County of Orange or MSSP site.

7. CalOptima shall establish and maintain a system of aging of Grievances that are pending and unresolved for thirty (30) calendar days or more.

IV. ATTACHMENT(S)

A. Acknowledgement Letter
B. Grievance Resolution Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy DD.2013: Exempt Grievance Process
D. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
E. CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~
F. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
G. CalOptima Policy HH.1108: State Hearings Process and Procedures
H. CalOptima Policy HH.1109: Complaint Decision Matrix
~~I. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations~~
~~J.~~I. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
~~K.~~J. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
K. Title 22, California Code of Regulations (C.C.R.), §53858
L. Title 22, California Code of Regulations (C.C.R.), §53858 (e)(4)
~~L.~~M. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
N. Title 42, Code of Federal Regulations (C.F.R.), §438.3(u)
O. Title 42, Code of Federal Regulations (C.F.R.), §§438.402, 406, 408, and 416

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 12/10/15: Department of Health Care Services
C. 06/29/15: Department of Health Care Services

VII. BOARD ACTION(S)

~~Not Applicable~~
None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	06/01/1996	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/1997	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2000	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2001	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	03/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2004	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2011	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2013	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	02/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal

Revised	TBD	HH.1102	Member Grievance	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an ~~Adverse~~Aadverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
Authorized Representative	~~Has the meaning given such term in Section 164.502(g) 45 CFR of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.~~For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
~~Complaint~~	~~For the purposes of this policy, the same as a Grievance.~~
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance.
Grievance Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An ~~oral or written~~ expression of dissatisfaction ~~with~~about any ~~aspect of the CalOptima program,~~matter other than an Adverse Benefit Determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

Term	Definition
In-Home Supportive Services (IHSS)	Services provided for Members in accordance with the requirements set forth in Welfare and Institutions Code Section 14186.1(c)(1).
Long Term Care	Care provided in a skilled nursing facility and sub-acute care services.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Multipurpose Senior Service Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home.
Non-Coverage Appeal	Grievances about decisions that are not related to utilization management decisions.
Resolution	The grievance has reached a final conclusion with respect to the Member or Provider's submitted grievance.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).

Policy #:	HH.1102
Title:	**Member Grievance**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/1996
Revised Date:	TBD

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves Grievances from a Member or a Member's Authorized Representative, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall establish and maintain a Grievance Process pursuant to which a Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a Grievance for review and Resolution.

B. CalOptima's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

C. A Member need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the complaint shall still be categorized as a Grievance.

D. CalOptima shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs.

E. CalOptima shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance, or may manage a Grievance under the supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

F. CalOptima shall process expedited requests timely in instances where a Provider indicates, or CalOptima determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

G. CalOptima shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance and he or she is not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease.

H. CalOptima shall refer all medical quality of care issues identified through the Grievance Process to the Quality Improvement Department for review.

I. CalOptima shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that he or she filed a Grievance.

J. CalOptima and a Health Network shall inform a Member of their right to file a Grievance through CalOptima at any time to express dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA), in accordance with the provisions of this policy.

   a. A Member's Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance at any time.

K. CalOptima and a Health Network shall inform a Member of their right to file an Appeal in accordance with CalOptima Policy GG.1510: Appeal Process.

L. CalOptima and a Health Network shall inform a Member, during the Grievance Process, of their right to request a State Hearing after the Appeal process, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures, GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, and GG.1510: Member Appeal Process.

M. CalOptima shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. CalOptima and a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances.

N. CalOptima shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Records, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or the Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent. CalOptima shall provide records at no cost.

O. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

P. CalOptima and a Health Network shall inform a Member of their right to file a Grievance with CalOptima or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

Q. CalOptima shall process Exempt Grievances in accordance with CalOptima Policy DD.2013: Exempt Grievance Process.

III. PROCEDURE

A. Assistance to Members

   1. CalOptima and a Health Network shall make complaint forms and procedures for filing a Grievance available to facilities that provide Covered Services to Members.

2. CalOptima shall provide complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances, and shall triage Member calls and route Grievances to GARS via its electronic system.

B. Grievance Process

1. A Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent**,** may file a Grievance:

   a. With CalOptima's Customer Service Department, by telephone, or in person; or

   b. With CalOptima GARS, by facsimile, in writing, or through the CalOptima website at www.caloptima.org.

   c. CalOptima shall provide language assistance, by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

   d. CalOptima will process the Grievance whether or not a signed written confirmation is received from the Member.

2. GARS shall:

   a. Date stamp and document the substance of the Grievance in the GARS database, verifying demographics and network affiliation.

   b. Determine the category of Grievance, including but not limited to the following categories: quality of care, quality of service, access to care, and other, based on the Grievance. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

   c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution.

   d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Grievance.

   e. Refer all Grievances related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

   f. Review and immediately process all Grievances that may seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited Grievance as required in the CalOptima contract with Department of Health Care Services (DHCS).

g. Escalate the Grievance for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Grievance.

h. Send the Member a Grievance Resolution Letter within thirty (30) calendar days after receipt of the Grievance.

i. For a standard Grievance, in the event the Resolution is not reached in thirty (30) days, notify the Member in writing of the status of the Grievance and provide an estimated completion date of Resolution, which shall not exceed fourteen (14) calendar days.

j. Translate Grievance correspondence into Threshold Languages, and offer oral interpretation for Grievance correspondence for all other languages; and

k. Provide an interpreter, or auxiliary aide, for assistance in the Grievance Process.

3. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a. Summary of the Member's Grievance;

b. The investigation made in the review process, including any referrals to the Quality Improvement Department for medical quality of care review;

c. When possible, the outcome of the review;

d. Alternative resources or references, when applicable; and

e. The Member's right to Appeal, as appropriate.

6. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, reviewing entity(ies), decision and any action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member and save the electronic file.

C. Non-Coverage Appeals

1. A Member or Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a request to appeal a decision not related to a utilization management decision with any supporting documentation to GARS within sixty (60) calendar days of the date of the Non-Coverage Decision Resolution Letter. This type of Grievance is considered a non-coverage appeal and is separate from the appeal process in CalOptima Policy GG.1510: Appeal Process.

2. A Member or Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may file the non-coverage appeal with CalOptima's Customer Service Department by telephone or in person; or with GARS via facsimile, in writing or through the CalOptima Website at www.caloptima.org.

3. CalOptima shall provide language assistance by CalOptima staff for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages.

4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.

5. Upon receipt of the Non-Coverage Appeal GARS shall:

    a. Date stamp and document the substance of the Non-Coverage Appeal into its electronic system, verifying demographics and network affiliation;

    b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s);

    c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the non-coverage appeal;

    d. Triage and investigate the Non-Coverage Appeals and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Complaint;

    e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Chief CMO or their Designee and any action deemed necessary under the quality review process;

    f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within seventy-two (72) hours of receipt;

    g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance.

        i. CalOptima shall translate Grievance Resolution Letters into Threshold Languages and offer oral interpretation for a Grievance Resolution Letter, written in English, for all other languages.

        ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests to be in CalOptima Direct - Administrative, and for access to out-of-network Providers or change of Health Networks, the resolution letter shall include:

            1) Summary of the Member's Non-Coverage Appeal;

            2) Description of actions taken to review the request;

            3) Date and name of position of staff involved in the review;

            4) Date of the issuance of the decision.

6. CalOptima shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter.

7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity (ies), decision and any action taken (if any), include a copy of the Resolution Letter and document any oral notification provided to the Member, and resolution date.

E. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Grievance Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Grievances in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

F. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, and related procedures regarding the Grievance Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Grievance, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Grievance Resolution Letters and Notice of Appeal Resolution letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. On a quarterly basis, CalOptima shall submit all recorded Member Grievances related to access to care, quality of care and denial of services to the Quality Improvement Committee (QIC) to review and take appropriate action to remedy any problems identified in such reviews.

4. CalOptima shall submit a report of aggregated Grievance data, as required, to DHCS.

5. CalOptima shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

6. CalOptima shall submit a report of Grievances related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Grievances or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Grievance was reported to the County of Orange or MSSP site.

7. CalOptima shall establish and maintain a system of aging of Grievances that are pending and unresolved for thirty (30) calendar days or more.

IV. ATTACHMENT(S)

A. Acknowledgement Letter
B. Grievance Resolution Letter

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy DD.2013: Exempt Grievance Process
D. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
E. CalOptima Policy GG.1510: Appeal Process
F. CalOptima Policy HH.1103: CalOptima Health Network Member Complaint
G. CalOptima Policy HH.1108: State Hearings Process and Procedures
H. CalOptima Policy HH.1109: Complaint Decision Matrix
I. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
J. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
K. Title 22, California Code of Regulations (C.C.R.), §53858
L. Title 22, California Code of Regulations (C.C.R.), §53858 (e)(4)
M. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c), (g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
N. Title 42, Code of Federal Regulations (C.F.R.), §438.3(u)
O. Title 42, Code of Federal Regulations (C.F.R.), §§438.402, 406, 408, and 416

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 12/10/15: Department of Health Care Services
C. 06/29/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1996	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/1997	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2000	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	08/01/2001	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	03/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2003	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2004	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2011	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2013	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	01/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2014	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	02/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1102	CalOptima Member Complaint	Medi-Cal
Revised	TBD	HH.1102	Member Grievance	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Aadverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance.
Grievance Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
In-Home Supportive Services (IHSS)	Services provided for Members in accordance with the requirements set forth in Welfare and Institutions Code Section 14186.1(c)(1).
Long Term Care	Care provided in a skilled nursing facility and sub-acute care services.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Multipurpose Senior Service Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home.
Non-Coverage Appeal	Grievances about decisions that are not related to utilization management decisions.
Resolution	The grievance has reached a final conclusion with respect to the Member or Provider's submitted grievance.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).

1

<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

<DATE>

<FIRST AND LAST NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <MR/MS LAST NAME>:

This letter is in response to your complaint filed on <insert the date filed> about <insert the member's issue(s) or concern(s)>. Thank you for taking the time to share your concerns with us. We are sorry for any trouble this may have caused you.

In your complaint, you stated <insert the member's statement>.

<STANDARD GRIEVANCE> Grievance and Appeals Resolution Services reviewed your complaint <summary of your investigation, outcomes, referrals, alternative resources or references when applicable including name(s) of person(s) contacted, department, medical group & any outcomes that are relevant to member not subject to peer review protection>.

<QUALITY OF CARE INSERT: Also, I have referred your concerns to CalOptima's Quality Improvement (QI) department to review the health care you received. The reason for this review is to decide if the health care provided meets the professional standards in the community. You will receive an acknowledgment letter from the QI department explaining the review process. The review process normally takes 120 days to complete. If the standards have been met, no further action is needed. If not, CalOptima will take the correct action necessary. California law does not let us share the details of this review.

CalOptima will take all required actions to solve your concerns. All member concerns, including those that could be related to quality of care, fraud and abuse, quality of service, or access problems are taken very seriously. We monitor these issues to look for ways to improve our program and prevent future problems. It is our goal to provide access to quality care and services to our members.

Your input is important to us and we are here to help you with your health care needs. If you have questions or concerns about this letter, please call me at **1-714-<PHONE NUMBER>.**

For future assistance or questions about your benefits, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at www.caloptima.org.

Sincerely,

<Resolution Specialist Name>, Resolution Specialist
Grievance and Appeals Resolution Services

Policy #:	HH.1103
Title:	~~CalOptima~~ **Health Network Member ~~Complaint~~ Grievance and ~~and &~~ Appeal Process~~Process~~**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/01/1996
~~Last~~ Revision Date:	~~07/01/17~~T BD

I. PURPOSE

This policy defines the process by which a Health Network shall address and resolve Grievances and Appeals for Members enrolled in the Health Network, under supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

II. POLICY

A. CalOptima may authorize a Health Network to manage Grievances and Appeals for Members enrolled in that Health Network.

B. If CalOptima authorizes a Health Network to manage Grievances and Appeals for Members enrolled in that Health Network:

1. The Health Network shall establish and maintain a Grievance and Appeals Process pursuant to which a Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a Grievance or Appeal for review and resolution.

2. The Grievances and Appeals Process shall address the receipt, handling, and disposition of Member Grievances and Appeals, in accordance with applicable statutory, regulatory, and contractual requirements.

3. The Health Network shall ensure prompt review and investigation of a Grievance or Appeal by management or supervisory staff responsible for the services or operations that are the subject of the Grievances or Appeals.

4. The Health Network shall ensure that the person making the final decision ~~on~~for the ~~Grievance or~~ proposed resolution of an Appeal ~~did not participate~~has neither participated in any prior ~~decision(s)~~decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

a. An Appeal of a denial based on lack of Medical Necessity;

b. A Grievance regarding denial of an expedited resolution of an Appeal; and

~~4.~~c. Any Grievance or Appeal involving clinical issues.

5. The Health Network shall immediately refer all medical quality of care issues to the Health Network's Medical Director or Designee for review.

6. The Health Network shall ensure that there is no discrimination against a Member on the grounds that the Member filed a Grievance or Appeal.

7. The Health Network shall ensure that its Members are informed of their right to Appeal a Health Network Utilization Management (UM) decision by filing a UM Appeal with the Health Network within sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) that denied, delayed, or modified a request for services.

8. The Member has the right to request an Appeal in the event that a Health Network fails to issue a NABD/NOA within the required ~~timeframe;~~time frame, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

C. The Health Network shall inform a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of his or her right to file a Grievance at any time regarding an incident or issue that caused the Member's dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) through CalOptima or the Health Network, in accordance with the provisions of this policy.

D. The Health Network shall inform a Member ~~or~~, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, during the Appeal Process, of his or her right to request a State Hearing after the Appeal Process has been exhausted or ~~should have been exhausted~~if the Health Network fails to send a resolution notice with thirty (30) calendar days of the Appeal being filed with the Health Network , and of his or her right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearing Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. The Health Network shall give a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individuals(s) resolving the Grievance or Appeal, evidence, testimony, facts and law in support of his or her Grievance. ~~In case of a Grievance subject to an expedited review,~~ or Appeal. CalOptima and the Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances and Appeals.

F. The Health Network shall provide the opportunity, before and during the Grievance and Appeal Process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Grievance and Appeal Process, upon request by the Member ~~or~~, his or her Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, at no cost.

G. The Health Network shall assist a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs as provided for in Section III.A.6.a of this Policy.

H. The Health Network shall inform a Member of his or her right to file a Grievance with CalOptima, the Health Network, or the Secretary of Health and Human Services regarding violations of the Member's privacy rights, in accordance with CalOptima Policy HH.~~3020~~3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

I. The Health Network shall not discriminate or retaliate against any Member, a Member's Authorized Representative, or a Provider on grounds that such Member filed a Grievance or Appeal~~, in accordance with CalOptima Policy HH.3012: Non-Retaliation on Reporting Violations~~.

III. PROCEDURE

A. A Health Network authorized to manage Grievances and Appeals for Members enrolled in that Health Network pursuant to Section II.B. of this policy, shall maintain a Grievance and Appeal Process as follows:

1. Filing a Grievance or Appeal

a. A Member or a Member's Authorized Representative may file a Grievance or Appeal with the Member's Health Network, by telephone, in person, facsimile, or in writing.

b. A Member may request continuation of services by requesting an Appeal within ten (10) calendar days after the NABD/NOA. The Health Network shall grant the Member continuation of the benefit until an Appeal decision is reached.

c. Assistance to Members

i. The Health Network shall make the complaint forms and procedures for filing a Grievance or Appeal available to facilities that provide services to Members.

ii. The Health Network shall promptly provide the complaint forms and procedures to a Member upon request.

iii. The Health Network Member Services staff shall assist a Member with respect to the filing of a Grievance or Appeal.

iv. The Health Network shall provide a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with Limited English Proficiency (LEP), disabilities, or cultural needs.

2. Acknowledgment of a Grievance or Appeal

a. Except as otherwise provided in Section III.A.4 of this policy, a Health Network shall send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance or Appeal indicating receipt of the Grievance or Appeal, the date of receipt of the Grievance or Appeal, identifying a Grievance Resolution staff person whom the Member may contact regarding the Grievance or Appeal and the estimated completion date of resolution.

b. In instances of an oral Appeal request (excluding expedited Appeals) made by the ~~member~~Member, CalOptima shall send a written confirmation of the oral Appeal for ~~member's~~Member's signature.

i. The date of the oral Appeal establishes the filing date for the Appeal.

ii. ~~In~~The Health Network will process the ~~event that CalOptima does~~Appeal whether or not ~~receive~~ a signed written~~, signed~~ Appeal confirmation is received from the Member~~, CalOptima shall neither dismiss nor delay resolution of the Appeal~~ Appeal.

c. A written confirmation does not apply to an oral grievance request.

~~c.~~d. If CalOptima receives a Member's Grievance or Appeal for a Health Network that manages Grievances or Appeals, CalOptima shall forward the Grievance or Appeal immediately to the Health Network Complaint staff for investigation and resolution.

3. Investigation and Resolution of a Grievance or Appeal

a. The Health Network Complaint staff shall promptly consult with the Health Network department responsible for the services or operations that are the subject of the Grievance or Appeal.

b. The Health Network Complaint staff shall review the factual findings, proposed resolution, and any other relevant information, and shall issue a Grievance Resolution Letter or Notice of Appeal Resolution to respond to the Grievance or Appeal.

c. The Health Network shall send the Member a Grievance Resolution Letter or Notice of Appeal Resolution as quickly as the Member's health condition requires, but not later than thirty (30) calendar days after receipt of the Grievance or Appeal, except as otherwise provided in Section III.A.4 of this policy.

d. The Grievance Resolution Letter ~~or Notice of Appeal Resolution~~ shall describe the Grievance ~~or Appeal~~, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. Summary of the Member's ~~Grievances or Appeals~~Grievance;

ii. The investigation made in the review process, including any referrals to the Quality Improvement Department for a quality of care review;

iii. When possible, the outcome of the review;

iv. Alternative resources or references, when applicable;

e. The Notice of Appeal Resolution shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

~~v.~~ The ~~The Member's right to Appeal, as appropriate; and~~

~~vi. The State Hearing process and Aid Paid Pending, as appropriate.~~

i. results of the resolution and the date it was completed;

ii. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

iii. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

iv. Alternative resources or references, when applicable;

v. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

~~e.~~f. The Health Network shall translate the Grievance Resolution Letter or Notice of Appeal Resolution into threshold languages and offer oral interpretation for a Grievance Resolution Letter or Notice of Appeal Resolution for all other languages upon request.

~~f.~~g. The Health Network shall take ~~immediate~~ action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

4. Expedited UM Appeal or Grievances

a. If the Health Network receives a Grievance or Appeal that involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain and potential loss of life, limb, or major bodily function, it shall process such Grievance or Appeals an Expedited UM Appeal or Grievance:

i. Upon receipt of the expedited review Appeal or Grievance information, the Health Network Chief Medical Officer (CMO), or his or her Designee, shall conduct a medical review.

ii. The Health Network shall utilize specialist consultants, as appropriate.

iii. The Health Network shall notify the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing.

iv. The Health Network shall make a decision on the Expedited UM Appeal or Grievance request as quickly as the medical condition requires, but no later than seventy-two (72) hours after the Expedited UM Appeal or Grievance request is made to the Health Network. The Health Network shall provide verbal notice of the resolution of the expedited review to the Member.

v. The Health Network shall notify the Member or the Member's Authorized Representative, and all involved Providers of the Expedited UM Appeal or Grievance decision by facsimile or verbal communication within seventy-two (72) hours after receiving the Expedited UM Appeal or Grievance. The Health Network shall provide a written notice within one (1) business day after a verbal notice.

b. The Health Network shall take immediate action to implement the decision, in accordance with the Expedited UM Appeal or Grievance decision.

~~5. Extension of Timeframes~~

~~a. A Health Network shall extend the resolution timeframes for either standard or expedited Appeals by up to fourteen (14) calendar days if any of the following two (2) conditions apply:~~

~~i. The Member requests the extension;~~

~~ii. The Health Network demonstrates to the satisfaction of the DHCS upon request, that there is a need for additional information and how the delay is in the Member's best interest.~~

~~b. For any extension not requested by the Member, the Health Network is required to provide the Member with written notice of the reason for the delay.~~

~~i. The Health Network shall make reasonable efforts to provide the Member with oral notice of the extension.~~

~~ii. The Health Network shall provide written notice of the extension within two (2) calendar days and notify the Member of the right to file a Grievance if the beneficiary disagrees with the extension.~~

~~iii. The Health Network shall resolve the Appeal as expeditiously as the Member's health condition requires but not beyond the initial fourteen (14) calendar day extension.~~

~~iv. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.~~

~~6.~~5. In addition to any rights set forth in this policy, a Member shall also have the right to:

a. Request the Health Network to provide an interpreter or auxiliary aide for assistance in the Grievance or Appeal Process, or to provide translation of Grievance or Appeal correspondence.

b. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

i. The Health Network shall notify a Member of this right annually, and in every Acknowledgement and resolution letter.

ii. A Member may request a State Hearing within one hundred and twenty (120) calendar days after the Notice of Appeal Resolution.

iii. To request a State Hearing, a Member may:

a) Write to: Department of Social Services
State Hearings Division

P. O. Box 944243, M.S. 19-37
Sacramento, CA 95814;

b) Call: (800) 952-5253, or for TDD only, (800) 952-8349;

c) Facsimile: 1-916-651-5210, or 916-651-2789; or

d) Present him or herself to the Department of Social Services at:

744 P Street
Sacramento, CA 95814

d. A Member may represent him or herself at the State Hearing, or may be represented by a friend, relative, attorney, or other representative.

e. Upon notice from CalOptima that a Member filed for a State Hearing, a Health Network shall grant Aid Paid Pending, if applicable, until the State Hearing occurs, or a decision is rendered, in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures and GG.1510: Appeal Process for Decisions Regarding Care and Services.

f. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.

~~7.~~6. Responsible Staff

a. The Health Network shall designate a manager with authority to require corrective actions to be responsible for receiving Grievance or Appeal, issuing Grievance or Appeal decisions, and reporting to CalOptima.

b. The CalOptima Director of GARS or Designee shall have primary responsibility for the oversight of the Health Network Grievance and Appeal Process, including referring any non-compliance to the CalOptima Compliance Department for review and action, if needed.

c. CalOptima's Chief Operating Officer shall have primary responsibility for:

i. Maintenance of the Grievance or Appeal Process;

ii. Review of the operations; and

iii. Review of any emerging patterns of Grievance or Appeal in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

~~8.~~7. Notices, Records, and Reports

a. Notice of Grievance or Appeal Procedures

i. Upon enrollment, and annually thereafter, the Health Network shall inform a Member, in writing, of the locations for filing a Grievance or Appeal, telephone numbers where a Complaint may be submitted, and related procedures regarding the Member Grievance or Appeal Process.

ii. The Health Network shall provide these notices in each of the Threshold Languages, as required by CalOptima.

b. Records

i. The Health Network shall maintain written records of each Grievance or Appeal, including at least the following information:

a) Date of receipt;

b) Member's name;

c) Nature of the Grievance or Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations as well as;

(i) Untimely assignments to providers;

(ii) Issues related to cultural and linguistic sensitivity;

(iii) Difficulty accessing specialists; and

(iv) Grievances related to out-of-network requests.

d) Names of Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the Grievance or Appeal; and

e) Disposition.

ii. The Health Network shall maintain the written records of each Grievance or Appeal, including the date of receipt, Member's name, description of the problem, names of the Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

c. Reporting Requirements

i. The Health Network shall send to CalOptima GARS:

a) A copy of the Grievance or Appeal, and

b) A copy of the Acknowledgement Letter, Grievance Resolution Letter, Notice of Appeal Resolution letter, and all supporting documentation that was used in investigation of the Grievance or Appeal upon request by CalOptima.

ii. The Health Network shall submit aggregate and detailed Grievance or Appeal data, in the format required by CalOptima to CalOptima's GARS Department on a quarterly basis, as outlined in the Health Network Reporting Due Date Matrix.

B. If CalOptima determines that a Health Network has failed to comply with the requirements of this policy, CalOptima may take appropriate action including, but not limited to, taking steps to resolve

a Member's Grievance or Appeal, implementing a decision, de-delegation of or Grievance and Appeal management for its assigned Members, or imposing corrective action or sanctions against the Health Network, in accordance with CalOptima Policies HH.~~2002~~2002Δ: Sanctions and HH.~~2005~~2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Grievance Resolution Letter
C. Notice of Appeal Resolution (Uphold)
D. Notice of Appeal Resolution (Overturn)
E. Health Network Reporting Due Date Matrix

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Policy HH.1108: State Hearing Process and Procedures
E. CalOptima Policy HH.~~2002~~2002Δ: Sanctions
F. CalOptima Policy HH.~~2005~~2005Δ: Corrective Action Plan
~~G. CalOptima Policy HH.3012: Non-Retaliation on Reporting Violations~~
~~H.~~G. CalOptima Policy ~~HH.3020~~3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
~~I.~~H. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~J.~~I. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c),(g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
~~K.~~J. Title 22, California Code of Regulations (C.C.R.), §53858
K. Title 42, Code of Federal Regulations (C.F.R.), §§438.406 (b)(3) and 438.420(a),(b), and (c)

VI. REGULATORY AGENCY APPROVAL(S)
~~VI.~~

A. 06/21/17: Department of Health Care Services
B. 12/10/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	06/1996	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/1997	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/2000	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/2001	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	04/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	03/01/2014	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1103	CalOptima Health Network Member Complaint & Appeal	Medi-Cal
Revised	02/07/2019	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
Authorized Representative	~~Has the meaning given such term in Section 164.502(g) 45 CFR of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.~~. For the purpose of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an appeal or grievance.
~~Complaint~~	~~For the purposes of this policy, the same as a Grievance.~~
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance or Appeal.
Grievance and Appeals Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances and Appeals.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.

Term	Definition
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Working Days	Shall mean state of California working day(s), defined in 8 CCR §330 as Monday through Fridays but not including Saturday, Sunday or State Holidays.

1

Policy #:	HH.1103
Title:	**Health Network Member Grievance and Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	06/01/1996
Revision Date:	TBD

I. PURPOSE

This policy defines the process by which a Health Network shall address and resolve Grievances and Appeals for Members enrolled in the Health Network, under supervision of CalOptima's Grievance and Appeals Resolution Services (GARS) Department.

II. POLICY

A. CalOptima may authorize a Health Network to manage Grievances and Appeals for Members enrolled in that Health Network.

B. If CalOptima authorizes a Health Network to manage Grievances and Appeals for Members enrolled in that Health Network:

1. The Health Network shall establish and maintain a Grievance and Appeals Process pursuant to which a Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member and with the Member's written consent, may submit a Grievance or Appeal for review and resolution.

2. The Grievances and Appeals Process shall address the receipt, handling, and disposition of Member Grievances and Appeals, in accordance with applicable statutory, regulatory, and contractual requirements.

3. The Health Network shall ensure prompt review and investigation of a Grievance or Appeal by management or supervisory staff responsible for the services or operations that are the subject of the Grievances or Appeals.

4. The Health Network shall ensure that the person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

   a. An Appeal of a denial based on lack of Medical Necessity;

   b. A Grievance regarding denial of an expedited resolution of an Appeal; and

   c. Any Grievance or Appeal involving clinical issues.

5. The Health Network shall immediately refer all medical quality of care issues to the Health Network's Medical Director or Designee for review.

6. The Health Network shall ensure that there is no discrimination against a Member on the grounds that the Member filed a Grievance or Appeal.

7. The Health Network shall ensure that its Members are informed of their right to Appeal a Health Network Utilization Management (UM) decision by filing a UM Appeal with the Health Network within sixty (60) calendar days of the date of the Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) that denied, delayed, or modified a request for services.

8. The Member has the right to request an Appeal in the event that a Health Network fails to issue a NABD/NOA within the required time frame, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

C. The Health Network shall inform a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of his or her right to file a Grievance at any time regarding an incident or issue that caused the Member's dissatisfaction about any matter other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) through CalOptima or the Health Network, in accordance with the provisions of this policy.

D. The Health Network shall inform a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, during the Appeal Process, of his or her right to request a State Hearing after the Appeal Process has been exhausted or if the Health Network fails to send a resolution notice with thirty (30) calendar days of the Appeal being filed with the Health Network , and of his or her right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearing Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. The Health Network shall give a Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individuals(s) resolving the Grievance or Appeal, evidence, testimony, facts and law in support of his or her Grievance or Appeal. CalOptima and the Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Grievances and Appeals.

F. The Health Network shall provide the opportunity, before and during the Grievance and Appeal Process, to examine the Member's case file, including Medical Records, and any other documents and records considered during the Grievance and Appeal Process, upon request by the Member, his or her Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, at no cost.

G. The Health Network shall assist a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs as provided for in Section III.A.6.a of this Policy.

H. The Health Network shall inform a Member of his or her right to file a Grievance with CalOptima, the Health Network, or the Secretary of Health and Human Services regarding violations of the

Member's privacy rights, in accordance with CalOptima Policy HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

I. The Health Network shall not discriminate or retaliate against any Member, a Member's Authorized Representative, or a Provider on grounds that such Member filed a Grievance or Appeal.

III. PROCEDURE

A. A Health Network authorized to manage Grievances and Appeals for Members enrolled in that Health Network pursuant to Section II.B. of this policy, shall maintain a Grievance and Appeal Process as follows:

1. Filing a Grievance or Appeal

a. A Member or a Member's Authorized Representative may file a Grievance or Appeal with the Member's Health Network, by telephone, in person, facsimile, or in writing.

b. A Member may request continuation of services by requesting an Appeal within ten (10) calendar days after the NABD/NOA. The Health Network shall grant the Member continuation of the benefit until an Appeal decision is reached.

c. Assistance to Members

i. The Health Network shall make the complaint forms and procedures for filing a Grievance or Appeal available to facilities that provide services to Members.

ii. The Health Network shall promptly provide the complaint forms and procedures to a Member upon request.

iii. The Health Network Member Services staff shall assist a Member with respect to the filing of a Grievance or Appeal.

iv. The Health Network shall provide a Member requiring assistance with filing a Grievance or Appeal, including, but not limited to, a Member with Limited English Proficiency (LEP), disabilities, or cultural needs.

2. Acknowledgment of a Grievance or Appeal

a. Except as otherwise provided in Section III.A.4 of this policy, a Health Network shall send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance or Appeal indicating receipt of the Grievance or Appeal, the date of receipt of the Grievance or Appeal, identifying a Grievance Resolution staff person whom the Member may contact regarding the Grievance or Appeal and the estimated completion date of resolution.

b. In instances of an oral Appeal request (excluding expedited Appeals) made by the Member, CalOptima shall send a written confirmation of the oral Appeal for Member's signature.

i. The date of the oral Appeal establishes the filing date for the Appeal.

ii. The Health Network will process the Appeal whether or not a signed written Appeal confirmation is received from the Member Appeal.

c. A written confirmation does not apply to an oral grievance request.

d. If CalOptima receives a Member's Grievance or Appeal for a Health Network that manages Grievances or Appeals, CalOptima shall forward the Grievance or Appeal immediately to the Health Network Complaint staff for investigation and resolution.

3. Investigation and Resolution of a Grievance or Appeal

a. The Health Network Complaint staff shall promptly consult with the Health Network department responsible for the services or operations that are the subject of the Grievance or Appeal.

b. The Health Network Complaint staff shall review the factual findings, proposed resolution, and any other relevant information, and shall issue a Grievance Resolution Letter or Notice of Appeal Resolution to respond to the Grievance or Appeal.

c. The Health Network shall send the Member a Grievance Resolution Letter or Notice of Appeal Resolution as quickly as the Member's health condition requires, but not later than thirty (30) calendar days after receipt of the Grievance or Appeal, except as otherwise provided in Section III.A.4 of this policy.

d. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. Summary of the Member's Grievance;

ii. The investigation made in the review process, including any referrals to the Quality Improvement Department for a quality of care review;

iii. When possible, the outcome of the review;

iv. Alternative resources or references, when applicable;

e. The Notice of Appeal Resolution shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision including but not limited to:

i. The results of the resolution and the date it was completed;

ii. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

iii. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

iv. Alternative resources or references, when applicable;

v. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

f. The Health Network shall translate the Grievance Resolution Letter or Notice of Appeal Resolution into threshold languages and offer oral interpretation for a Grievance Resolution Letter or Notice of Appeal Resolution for all other languages upon request.

g. The Health Network shall take action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

4. Expedited UM Appeal or Grievances

a. If the Health Network receives a Grievance or Appeal that involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain and potential loss of life, limb, or major bodily function, it shall process such Grievance or Appeals an Expedited UM Appeal or Grievance:

i. Upon receipt of the expedited review Appeal or Grievance information, the Health Network Chief Medical Officer (CMO), or his or her Designee, shall conduct a medical review.

ii. The Health Network shall utilize specialist consultants, as appropriate.

iii. The Health Network shall notify the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing.

iv. The Health Network shall make a decision on the Expedited UM Appeal or Grievance request as quickly as the medical condition requires, but no later than seventy-two (72) hours after the Expedited UM Appeal or Grievance request is made to the Health Network. The Health Network shall provide verbal notice of the resolution of the expedited review to the Member.

v. The Health Network shall notify the Member or the Member's Authorized Representative, and all involved Providers of the Expedited UM Appeal or Grievance decision by facsimile or verbal communication within seventy-two (72) hours after receiving the Expedited UM Appeal or Grievance. The Health Network shall provide a written notice within one (1) business day after a verbal notice.

b. The Health Network shall take immediate action to implement the decision, in accordance with the Expedited UM Appeal or Grievance decision.

5. In addition to any rights set forth in this policy, a Member shall also have the right to:

a. Request the Health Network to provide an interpreter or auxiliary aide for assistance in the Grievance or Appeal Process, or to provide translation of Grievance or Appeal correspondence.

b. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

i. The Health Network shall notify a Member of this right annually, and in every Acknowledgement and resolution letter.

ii. A Member may request a State Hearing within one hundred and twenty (120) calendar days after the Notice of Appeal Resolution.

iii. To request a State Hearing, a Member may:

a) Write to: Department of Social Services
State Hearings Division
P. O. Box 944243, M.S. 19-37
Sacramento, CA 95814;

b) Call: (800) 952-5253, or for TDD only, (800) 952-8349;

c) Facsimile: 1-916-651-5210, or 916-651-2789; or

d) Present him or herself to the Department of Social Services at:

744 P Street
Sacramento, CA 95814

d. A Member may represent him or herself at the State Hearing, or may be represented by a friend, relative, attorney, or other representative.

e. Upon notice from CalOptima that a Member filed for a State Hearing, a Health Network shall grant Aid Paid Pending, if applicable, until the State Hearing occurs, or a decision is rendered, in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures and GG.1510: Appeal Process for Decisions Regarding Care and Services.

f. In the event the Health Network fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.

6. Responsible Staff

a. The Health Network shall designate a manager with authority to require corrective actions to be responsible for receiving Grievance or Appeal, issuing Grievance or Appeal decisions, and reporting to CalOptima.

b. The CalOptima Director of GARS or Designee shall have primary responsibility for the oversight of the Health Network Grievance and Appeal Process, including referring any non-compliance to the CalOptima Compliance Department for review and action, if needed.

c. CalOptima's Chief Operating Officer shall have primary responsibility for:

i. Maintenance of the Grievance or Appeal Process;

ii. Review of the operations; and

iii. Review of any emerging patterns of Grievance or Appeal in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

7. Notices, Records, and Reports

   a. Notice of Grievance or Appeal Procedures

      i. Upon enrollment, and annually thereafter, the Health Network shall inform a Member, in writing, of the locations for filing a Grievance or Appeal, telephone numbers where a Complaint may be submitted, and related procedures regarding the Member Grievance or Appeal Process.

      ii. The Health Network shall provide these notices in each of the Threshold Languages, as required by CalOptima.

   b. Records

      i. The Health Network shall maintain written records of each Grievance or Appeal, including at least the following information:

         a) Date of receipt;

         b) Member's name;

         c) Nature of the Grievance or Appeal as detailed in Title 28, Section 1300.68(f)(2)(D) of the California Code of Regulations as well as;

            (i) Untimely assignments to providers;

            (ii) Issues related to cultural and linguistic sensitivity;

            (iii) Difficulty accessing specialists; and

            (iv) Grievances related to out-of-network requests.

         d) Names of Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the Grievance or Appeal; and

         e) Disposition.

      ii. The Health Network shall maintain the written records of each Grievance or Appeal, including the date of receipt, Member's name, description of the problem, names of the Health Network staff who received the Grievance or Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

   c. Reporting Requirements

      i. The Health Network shall send to CalOptima GARS:

         a) A copy of the Grievance or Appeal, and

b) A copy of the Acknowledgement Letter, Grievance Resolution Letter, Notice of Appeal Resolution letter, and all supporting documentation that was used in investigation of the Grievance or Appeal upon request by CalOptima.

ii. The Health Network shall submit aggregate and detailed Grievance or Appeal data, in the format required by CalOptima to CalOptima's GARS Department on a quarterly basis, as outlined in the Health Network Reporting Due Date Matrix.

B. If CalOptima determines that a Health Network has failed to comply with the requirements of this policy, CalOptima may take appropriate action including, but not limited to, taking steps to resolve a Member's Grievance or Appeal, implementing a decision, de-delegation of or Grievance and Appeal management for its assigned Members, or imposing corrective action or sanctions against the Health Network, in accordance with CalOptima Policies HH.2002Δ: Sanctions and HH.2005Δ: Corrective Action Plan.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Grievance Resolution Letter
C. Notice of Appeal Resolution (Uphold)
D. Notice of Appeal Resolution (Overturn)
E. Health Network Reporting Due Date Matrix

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Policy HH.1108: State Hearing Process and Procedures
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Policy HH.2005Δ: Corrective Action Plan
G. CalOptima Policy HH.CalOptima Policy 3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information
H. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
I. Title 28, California Code of Regulations (C.C.R.), §§1300.68 (except Subdivision 1300.68(c),(g), and (h)) and 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
J. Title 22, California Code of Regulations (C.C.R.), §53858
K. Title 42, Code of Federal Regulations (C.F.R.), §§438.406 (b)(3) and 438.420(a),(b), and (c)

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 12/10/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/1996	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/1997	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/2000	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	08/2001	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	04/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/2003	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	12/01/2005	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2007	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	01/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2009	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	03/01/2014	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	10/01/2015	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	06/01/2016	HH.1103	CalOptima Health Network Member Complaint	Medi-Cal
Revised	07/01/2017	HH.1103	CalOptima Health Network Member Complaint & Appeal	Medi-Cal
Revised	02/07/2019	HH.1103	Health Network Member Grievance & Appeal Process	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
Authorized Representative	. For the purpose of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an appeal or grievance.
Acknowledgment Letter	A written statement acknowledging receipt of a Grievance or Appeal.
Grievance and Appeals Process	The process by which CalOptima and its Health Networks address and provide resolution to all Grievances and Appeals.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An oral or written expression of dissatisfaction with any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Working Days	Shall mean state of California working day(s), defined in 8 CCR §330 as Monday through Fridays but not including Saturday, Sunday or State Holidays.

<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

<DATE>

<FIRST AND LAST NAME>
<ADDRESS>
<CITY, STATE ZIP>

Dear <MR/MS LAST NAME>:

This letter is in response to your complaint filed on <insert the date filed> about <insert the member's issue(s) or concern(s)>. Thank you for taking the time to share your concerns with us. We are sorry for any trouble this may have caused you.

In your complaint, you stated <insert the member's statement>.

<STANDARD GRIEVANCE> Grievance and Appeals Resolution Services reviewed your complaint <summary of your investigation, outcomes, referrals, alternative resources or references when applicable including name(s) of person(s) contacted, department, medical group & any outcomes that are relevant to member not subject to peer review protection>.

<QUALITY OF CARE INSERT: Also, I have referred your concerns to CalOptima's Quality Improvement (QI) department to review the health care you received. The reason for this review is to decide if the health care provided meets the professional standards in the community. You will receive an acknowledgment letter from the QI department explaining the review process. The review process normally takes 120 days to complete. If the standards have been met, no further action is needed. If not, CalOptima will take the correct action necessary. California law does not let us share the details of this review.

CalOptima will take all required actions to solve your concerns. All member concerns, including those that could be related to quality of care, fraud and abuse, quality of service, or access problems are taken very seriously. We monitor these issues to look for ways to improve our program and prevent future problems. It is our goal to provide access to quality care and services to our members.

Your input is important to us and we are here to help you with your health care needs. If you have questions or concerns about this letter, please call me at **1-714-<PHONE NUMBER>.**

For future assistance or questions about your benefits, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at www.caloptima.org.

Sincerely,

<Resolution Specialist Name>, Resolution Specialist
Grievance and Appeals Resolution Services

[CalOptima logo]

"Uphold"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

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

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf]* appealed the *[denial, delay, modification, or termination]* of *[Service requested]*.

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to uphold the decision. This request is still denied. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you need help reading this letter or have any questions, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff

who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

[Medical Director name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

[CalOptima logo]

"Overturn"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

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

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf],* appealed the *[denial, delay, modification, or termination]* of *[Service requested].*

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to overturn the original decision. This request is now approved. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision].*

[CalOptima] has 72 hours to approve or provide you the service.

Your request has been approved *[under authorization number <#> from <date> to <date> with <provider> or payment has been made].* On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

If you need help reading this letter or have any questions, please call, *[Grievance and Appeals Resolution Services Staff Name],* at *[telephone number].*

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

Grievance and Appeals

Timely and Appropriate Submission Grid

Year: 2018
Release: 2
Release Date: 1/2/18

Per CalOptima policy HH.2003, *Health Network Reporting* , Health Networks and Delegated Entities (as defined in the policy) are responsible for the submission of reports to CalOptima as specified in their Contract, the Report Binder/Timely and Appropriate Submission Grid, and/or CalOptima's policies and procedures.

Health Networks and Delegated Entities shall submit reports in the time, manner, and file format specified in this Timely and Appropriate Submission Grid, which includes the report frequency, naming convention and FTP folder.

Health Network and Delegated Entity reports shall be considered timely and appropriate when submitted by the due date, on the current template, and completed correctly. Failure to submit reports as specified may result in corrective action in accordance with CalOptima policies HH.2002, *Sanctions* , and HH.2005, *Corrective Action Plan* .

If the due date of a report, other than Model of Care (MOC) reports, falls on a weekend or holiday, the report is due the following business day by 2 pm. If the due date of a MOC report falls on a weekend or holiday, the report is due the prior business day by 5 pm.

For Health Network and Delegate Entity reporting requirements, please see the following worksheets:
"Report Grid": Lists the reporting requirements, including report frequency, naming convention and FTP folder
"Change Log": Lists any recent changes made to reporting requirements

Should you have any questions about reporting requirements, please contact healthnetworkdepartment@caloptima.org.

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Timely and Appropriate Submission Grid

Year: 2018
Release: 2
Release Date: 1/2/18

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
Claims XML Universe	Health Networks are required to report a complete Claims Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_CLM_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All	x		x	x	x	x
Claims Universe Case Files	Health Networks are required to submit monthly Claims Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_CLAIMS_**LB**_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	All	x		x	x	x	x
Credentialing Universe Monthly Case Files	Health Networks are required to submit Credentialing Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_CRED_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	PDF	All	x			x	x	x
Credentialing Annual Universe	Health Networks are required to report an annual Credentialing universe of all currently contracted providers at the time the report is run.	Audit and Oversight	**Annually** **January 15**	2_AORPT_QIRPT_**HN_YYYY**_CRED	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	All	x		x	x	x	x
Expedited Initial Organization Determination Log (OneCare & OneCare Connect)	Health Networks are required to report Expedited Initial Organization Determination requests for reporting and auditing. CalOptima will review the log weekly to monitor processing compliance and will notify the Health Network if there are any discrepancies or concerns.	Audit and Oversight	**Weekly** **Every Friday between 12:00-2:00 p.m.**	1_AORPT _**HN**_EIOD_**MMDDYYYY**_LB	HN = Health network # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Excel	OneCare, OneCare Connect	x			x	x	
NOMNC Log (OneCare & OneCare Connect)	Health Networks are required to report monthly NOMNC for reporting and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_AORPT_**HN_MMYYYY**_NOMNC_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Word	OneCare, OneCare Connect	x			x		

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REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
NOMNC Files (OneCare & OneCare Connect)	Health Networks are required to submit monthly NOMNC files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_NOMNC_FILES_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	OneCare, OneCare Connect	x			x		
PDR XML Universe	Health Networks are required to report a complete PDR Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_PDR_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All	x		x	x	x	x
PDR Universe Case Files	Health Networks are required to submit monthly PDR Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_PDR_**LB**_FILES	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare	hn_reporting	PDF	All	x		x	x	x	x
UM XML Universe	Health Networks are required to report a complete UM Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_UM_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All	x			x	x	x
UM Universe Case Files	Health Networks are required to submit monthly UM Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY_LB**_Files	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	All	x			x	x	x
HN Dashboard	Health Network performance results to support compilation of monthly Health Network Dashboard (deliverable to Audit and Oversight Committee)	Audit and Oversight	**Monthly** **15th of each month**	2_HMRPT_CSRPT_**HN_MMYYYY**_Dashboard	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	All	x		x	x	x	
Provider Directory Universe	Health Networks are required to report a complete Provider Directory Universe for quarterly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the files selected on a quarterly basis.	Audit and Oversight	**Quarterly** **January 10, April 10, July 10, October 10**	1_AORPT_**HN_MMYYYY**_PD	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	All	x		x	x	x	
DHCS APL 17-005 Data Certification Statement	Per DHCS APL 17-005, Health Networks and delegates are required to certify that data submitted to CalOptima monthly is accurate, complete, and truthful.	Audit and Oversight	**January 2018 only**	1_AORPT_**HN**_Data Certification_**MMYYYY**	HN = Health network #	hn_reporting	PDF	Medi-Cal	x		x	x		x
Customer Service Call Log Universe	Health Networks are required to submit monthly Customer Service call logs for auditing.	Audit and Oversight	**Quarterly** **January 7, April 7, July 7, October 7**	MC: 1_AORPT_**HN**_ODAG-14_CS_MC_**MMYYYY** OC: 1_AORPT_**HN**_ODAG-14_CS_OC_**MMYYYY** OCC: 1_AORPT_**HN**_MMP-SARAG-12_CS_DB_**MMYYYY**	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	All	x		x	x	x	

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Credentialing Monthly Universe	Health Networks are required to report a complete Credentialing Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight and Quality Improvement	**Monthly** **2nd of every month**	2_AORPT_QIRPT_**HN_MMYYYY**_CRED	MM = 2 digit month	hn_reporting	Excel	All	x		x	x	x	x
Mental Health Continuity of Care (Medi-Cal) - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org	YYYY= 4 digit year	Secure email	Excel	Kaiser						x
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	Kaiser						x
Mental Health Referrals (Medi-Cal) - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	Kaiser						x
BHT Reporting Template - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **28 days after the end of each quarter**	CalOptima.BHT.Mar.2016 Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	Kaiser						x
Mental Health Continuity of Care (Medi-Cal) - Magellan	MCE DHCS Reporting	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_MC_COC	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	hn_reporting	Excel	Medi-Cal					x	
Mental Health Referrals (Medi-Cal) - Magellan	MCE DHCS Reporting	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_MC_Referrals	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	hn_reporting	Excel	Medi-Cal					x	
BHT Reporting Template - Magellan	MCE DHCS Reporting	Behavioral Health	**Quarterly** **28 days after the end of each quarter (Q1 2018 only)**	1_BHRPT_**HN_MMYYYY**_DHCS_BHT_TEMPLATE	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	hn_reporting	Excel	Medi-Cal					x	
DHCS Monthly Reporting - Magellan	DHCS report	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_DHCS_Monthly	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal					x	
DHCS Provider Report - Magellan	DHCS report	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_DHCS_Provider	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	hn_reporting	PDF	Medi-Cal					x	
MH Provider Supplemental Directory	Used to populate CalOptima's online and print provider directories.	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_Supplemental_Provider_Directory CalOpt_Monthly_Provider_Supplemental_Directory_MMDDYYYY	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY - 4 digit year	Email to Kenny Chhuor, Natalie Zavala, Edwin Poon	Excel	All					x	
Claims Lag With Member Months - Magellan	Claims lag with member months	Behavioral Health	**January 2018 only**	1_BHRPT_**HN_MMYYYY**_M13	HN = Health network reporting # MM = 2 digit month YYYY - 4 digit year	hn_reporting	Excel	Medi-Cal					x	

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
Case Management Program Description	The case management program description is the description of the PMG and HN annual Case Management programs. It is a required submission as part of audit and oversight activities to ensure the respective case management programs are adhering to the standards required by our various governing agencies – CMS or DMHC – or for NCQA accreditation. The essential components of the case management program are specifically addressed in MA.6009 – Care Management and Coordination Process and GG.1301-Complex Case Management Process.	Case Mgmt	**Annually** **February 15th**	1_CMRPT_**HN**_Annual**YYYY**_CMPD	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	Kaiser						x
Case Management Log	This log is required as a part of oversight activities for maintenance of NCQA accreditation and is for the Medi-Cal and OneCare Connect population only. Through the log, case management referral activities are tracked based on data and referral sources as are members in the various levels of care management from Complex to Service Coordination. "Add on" services are also noted	Case Mgmt	**Monthly** **15th of every month**	1_CMRPT_**HN_MMYYYY**_CM	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal, OneCare Connect	x					x
Birth Outcomes	Birth Outcomes reporting	Case Mgmt	**Quarterly** **January 30, April 30, July 30, October 30**	1_CMRPT_**HN_QTYYYY**_BOC	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal	x					x
Continuity of Care (OneCare Connect)	Continuity of Care reporting for OneCare Connect members	Case Mgmt	**Weekly** **Every Tuesday by 10 am for the prior week's activity**	1_CMRPT_**HN_MMDDYYYY**_COCDB	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	Managed_HN_Reporting	Excel	OneCare Connect	x				x	
OneCare Connect Care Transition Log	As part of the program monitoring of OneCare Connect (OCC), the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) require CalOptima to report on transitions of member care.	Case Mgmt	**Monthly** **15th of the month**	1_CMRPT_**HN_MMYYYY**_Transitions	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	OneCare Connect	x				x	
OneCare Connect Care Transition Supporting Documentation	Supporting documentation for each transition of member care as reported in the OneCare Connect Care Transitions Log.	Case Mgmt	**Monthly** **15th of the month** **Ongoing, per process**	**HN_CIN**_Transition_**MMDDYYYY**	HN = Health network reporting # CIN = Member CIN MM = 2 digit month DD - 2 digit day YYYY= 4 digit year **MMDDYYYY is date of**	OCC/RevisedMOC/Inbound	PDF	OneCare Connect	x				x	
Interdisciplinary Care Team (ICT) Bundle (OneCare)	Individual bundles with ICT minutes and ICP	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBER CIN**_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY = 4 digit	OneCare/RevisedMOC/Inbound	PDF	OneCare	x					
Pediatric Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Individual bundles with ICT minutes and ICP	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_PEDS_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	Medi-Cal	x					
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Individual bundles with ICT minutes and ICP	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	Medi-Cal	x					

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Individual bundles with ICT minutes and ICP.	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY = 4 digit year	OCC/RevisedMOC/Inbound	PDF	OneCare Connect	x					
LTC Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Individual bundles with ICT minutes and ICP.	Case Mgmt (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_LTC_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY = 4 digit year	OCC/RevisedMOC/Inbound	PDF	OneCare Connect	x					
MOC Tracking Log (OneCare)	Report with OneCare PCC assignments and Care Management Levels	Case Mgmt (MOC)	**Monthly** **6th of the month**	**HN**571**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OneCare/RevisedMOC/Inbound	Pipe delimited text file	OneCare	x					
MOC SPD Tracking Log (Medi-Cal)	Report with indicated SPD member PCC assignments and Care Management Levels	Case Mgmt (MOC)	**Monthly** **6th of the month**	**HN**271**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	SPD Revised MOC/Inbound	Pipe delimited text file	Medi-Cal	x					
MOC Tracking Log (OneCare Connect)	Report with OneCare Connect PCC assignments and Care Management Levels	Case Mgmt (MOC)	**Monthly** **6th of the month**	**HN**871**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inbound	Pipe delimited text file	OneCare Connect	x					
Organ Transplant	Report of members with organ transplant	Case Mgmt	**Monthly** **15th of every month**	1_CMRPT_04_**MMYYYY**_OT	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Kaiser						x
Network Staff Legend File	Report PCC and other care coordinator staff names, training status, manager and percentage of time working on Medi-Cal, OneCare and OneCare Connect	Case Mgmt (MOC)	**Monthly** **6th of every month**	**HN**429**YYYYMMDD**	HN = Health network reporting # YYYY = 4 digit year MM = 2 digit month DD = 2 digit day	/RevisedMOC/Inbound	Text File	All	x					
Implementation Audit (SPD)	Networks submit documentation of implementation, hospitalization key event, and non-hospitalization key event.	Case Mgmt	**Monthly** **4th Thursday**	**HN_Member CIN**_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	MediCal/RevisedMOC/Inbound	PDF	Medi-Cal	x					
Implementation Audit (OneCare)	Networks submit documentation of implementation, hospitalization key event, and non-hospitalization key event.	Case Mgmt	**Monthly** **4th Thursday**	**HN_Member CIN**_OC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OC/RevisedMOC/Inbound	PDF	OneCare	x					
Implementation Audit (OneCare Connect)	Networks submit documentation of implementation, hospitalization key event, and non-hospitalization key event.	Case Mgmt	**Monthly** **4th Thursday**	**HN_Member CIN**_OCC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inbound	PDF	OneCare Connect	x					

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
Claims Third Party Liability	Networks report their potential TPL data to CalOptima and we submit to DHCS	Claims	**Monthly** **30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	Medi-Cal	x					x
Claims Third Party Liability (OneCare Connect)	Networks report their potential TPL data to CalOptima and we submit to DHCS	Claims	**Monthly** **30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL_DB	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	OneCare Connect	x			x		
Claims Timeliness Reports (Medi-Cal)	Health Networks shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision2. Financial Audit Reports Paragraph B. 2).	Compliance	**Monthly** **15th of every month** **Quarterly** **January 30, April 30, July 30, October 30**	1_HNRPT_**HN_MMYYYY**_MTRMC (Monthly) 1_HNRPT_**HN_QTYYYY**_MTRMC (Quarterly)	HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal	x					x
Provider Disputes (Medi-Cal)	Health networks are required to report quarterly Provider Dispute Resolution data. CalOptima compiles the data and reports to Regulatory affairs.	Compliance	**Quarterly** **January 30, April 30, July 30, October 30**	1_HNRPT_**HN_QTYYYY**_PDMC	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Call Center Statistics	Per the Medicare Marketing Guidelines, Call Center Requirements includes: • Limit average hold time to two (2) minutes. The average hold time is defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. • Answer eighty (80) percent of incoming calls within thirty (30) seconds • Limit the disconnect rate of all incoming calls to five (5) percent Health Networks must report: • Calls by Language • Abandonment Rate • Average Speed of Answer, Average Length of Call, Number of Auth/Referral Calls, Number of Claims Calls, Number of Member Cost Calls	Customer Service	**Quarterly** **January 30, April 30, July 30, October 30**	2_CSRPT_QIRPT_**HN_QTYYYY**_CCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	All	x		x	x	x	x
DHCS NMT/NEMT Report - Kaiser	Kaiser to submit the DHCS Non-Medical Tranportation (NMT)/Non-Emergency Medical Transportation (NEMT) reporting template. Each report is due 90 calendar days after the end of each month.	Customer Service	**Monthly** **27th of every month**	2_CSRPT_GARSRPT_04_NMT-NEMT_**MMYYYY**	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Kaiser						x
Annual Audited Financial Statements	Annual audited financial statements of the organization (PHC and SRG only).	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_AAFS	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	All	x				x	
IBNR Documentation	Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims, and supporting documentation for the IBNR calculation. Can be included in Annual Audited Financial Statements, or submitted as a separate report.	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	All	x					

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
Medical Loss Ratio	Reporting of the Health Network Medical Loss Ratio. Medi-Cal Expansion reported separately from Medi-Cal (classic). SRG completes only the "P" tabs. PHC completes the "P" and "H" tabs. HMO (except Kaiser) completes the HMO template.	Finance	**Interim: January - June due August 15.** **Interim: January - December due February 15.** **Final: Annual submission of all 12 months due June 30.**	1_FINRPT_**HN_SemiAnnualYYYY**_MLR 1_FINRPT_**HN_AnnualYYYY**_MLR 1_FINRPT_**HN_FinalYYYY**_MLR	HN = Health network reporting # YYYY= 4 digit year	hn_reporting	Excel (using most current AFRF)	Medi-Cal, OneCare Connect	x				x	x
Risk Bearing Organization (RBO) Report	Quarterly and annual financial data submitted by networks to DMHC (PHC and SRG only).	Finance	**Annual submission due 150 days after the fiscal year ends.** **Quarterly submissions due:** **February 15, May 15, August 15, November 15**	1_FINRPT_**HN**_Annual**YYYY**_DMHC (Annual) 1_FINRPT_**HN_QTYYYY**_DMHC (Quarterly)	HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter #	hn_reporting	PDF or Excel	All	x				x	
Total Business Reports	Quarterly unaudited financial statements of the PHC and SRG organization including balance sheet, income statement, statement of cash flows and related disclosures (PHC and SRG only).	Finance	**Quarterly submissions due:** **February 15, May 15, August 15, November 15**	1_FINRPT_**HN_QTYYYY**_TBFS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF or Excel	All	x				x	
Member All Grievance Log	DHCS: Quarterly log containing details of each case included in the Member All Grievances Summary	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QTYYYY**_GrievLog	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Member All Grievances Summary	DHCS: Quarterly report of grievances and appeals closed within the quarter; tracking volume and types of cases	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QTYYYY**_AllMbr	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Member CBAS Summary	DHCS: Quarterly report of grievances related to Community Based Adult Services closed within the quarter	GARS	**Quarterly** **January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_CBAS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
DHCS Quarterly Report	Quarterly report of grievances and appeals received within the quarter; tracks grievance types	GARS	**Quarterly** **January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_DHCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Member SPD Grievances Summary	DHCS: Quarterly report of grievances and appeals closed within the quarter, filed by SPD members; tracking volume and types of cases (subset of Member All Grievances Summary)	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QTYYYY**_SPD	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser						x
Disease Management Evaluation	The organization must identify a minimum of two chronic condition for which it has implemented a DM program. The conditions should be relevant to the organization s population (including high-risk pregnancy); however, primary prevention may not be included as a disease management condition. The components of the DM program should meet the	Health Education and Disease Management	**Annually** **1st Quarter**	1_DMRPT_04_Annual**YYYY**_DM	YYYY= 4 digit year	hn_reporting	Excel or Word or PDF	Kaiser						x
Health Education Calendar		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HECALENDAR	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Kaiser						x
Health Education Individual Encounters		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEIE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	Kaiser						x

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
Health Education Other Encounters		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEOE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	Kaiser						x
Hep C Pharmacy Data File		IS	**Monthly** **15th of every month**	04269**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	Incoming	Text File	Kaiser						x
CBAS Report		Long Term Support Services	**Monthly** **20th of every month**	KaiserPermanente_PRD_HCBShighind_CalOptima_**yyyymm**.txt	YYYY= 4 digit year MM = 2 digit month	Incoming	Text File	Kaiser						x
Health Network Newly Contracted Provider Training Report	Health Networks shall initiate, provide, and complete all educational training to all Provider s within ten (10) working days from the Provider s placement on active status. Health Networks shall obtain a signed acknowledgment	HNR	**Quarterly** **January 25, April 25, July 25, October 25**	1_HMRPT_**HN_QTYYYY**_NCT	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	All	x			x	x	x
Utlization Report - ASH	American Speciality Health/ASH report monthly fitness center/gym utilization data.	HNR	**Monthly**	Send via email to healthnetworkdepartment@caloptima.org		Secure email	Excel	ASH		x				
Out of Network Requests	Health Networks report out-of-network requests from all enrolled members and approvals by specialty type.	Quality Analytics	**Quarterly** **January 25, April 25, July 25, October 25**	1_MDMRPT_**HN_QTYYYY**_OON	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal	x					x
Access and Availability Report	Annual analysis of data to measure performance against standards for access. Report must also include BH access standards.	Quality Analytics	**Annually** **February 15**	1_MDMRPT_04_Annual**YYYY**_Access	YYYY = 4 digit year	hn_reporting	Excel or Word or PDF	Kaiser						x
QI Program	Health Networks shall develop an annual quality improvement report and submit to CalOptima for review.	Quality Improvement	**Annually** **February 15th**	1_QIRPT_**HN**_Annual**YYYY**_QIP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x		x	x	x	x
QI Evaluation (Previous Year)	Health Networks shall perform an annual evaluation of their quality improvement work plan/program and submit to CalOptima for review.	Quality Improvement	**Annually** **February 15th**	1_QIRPT_**HN**_Annual**YYYY**_QIE	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x		x	x	x	x
QI Work Plan Current Year (Initial)	Health Networks must develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	Quality Improvement	**Annually** **February 15th (for new year)**	1_QIRPT_**HN**_Annual**YYYY**_QICY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All	x		x	x		x
QI Work Plan (ICE)	Health Networks must report progress towards quality improvement program goals semi-annually.	Quality Improvement	**Semi-Annually** **February 15th and August 15th**	1_QIRPT_**HN**_SemiAnnual**YYYY**_QI	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All	x		x	x	x	x
Authorization Utilization Report	Health Networks report open authorizations, if a claim was received and the date the claim was paid (if applicable).	Quality Improvement	**Quarterly** **Q3 2016 - February 15** **Q4 2016 - May 15** **Q1 2017 - August 15** **Q2 2017 - November 15**	1_QIRPT_**HN_QTYYYY**_AUTH	HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal	x					
UM Program	Health Networks shall develop a utilization management program description and submit to CalOptima for review.	Utilization Management	**Annually** **February 15th**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x			x		x

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS	HN Indicator	ASH Indicator	VSP Indicator	Liberty Dental Indicator	Magellan Indicator	Kaiser Indicator
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their utilization management work plan/program and submit to CalOptima for review.	Utilization Management	**Annually** **February 15th**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UME	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x			x		x
UM Work Plan Current Year (Initial)	Health Networks must develop an annual utilization management work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	Utilization Management	**Annually** **February 15th (for new year)**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMCY	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	All	x			x	x	x
UM Work Plan (ICE)	Health Networks must report progress towards utilization management program goals semi-annually.	Utilization Management	**Semi-Annually** **February 15th and August 15**	2_UMRPT_AORPT_**HN**_SemiAnnual**YYYY**_UMCY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All	x			x	x	x
UM Committee Meeting Minutes	Health Networks must keep record of utilization management committee meetings through minutes	Utilization Management	**Semi- Annually** **February 15th and August 15th**	2_UMRPT_AORPT_**HN**_SemiAnnuall**YYYY**_Minutes	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All	x			x	x	x
Dental Anesthesia Report	The Department of Health Care Services (DHCS) now requires reporting of dental general anesthesia services. The health networks will report quarterly the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability.	Utilization Management	**Quarterly** **15th after the end of the quarter**	1_UMRPT_**HN_QTYYYY**_DA	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal	x					x
Nurse Advice Line Call Log	Each week on Monday, the health networks will submit the completed Nurse Advice Line Call Log for the previous week s activity	Utilization Management	**Weekly** **Every Monday for the previous weeks activity**	1_NARPT_**HN_MMDDYYYY**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD = 2 digit day Use date of submission	hn_reporting	Excel	OneCare, OneCare Connect	x					

Timely and Appropriate Submission Grid Change Log - 2018

Report Name	Release Number	Date of Release	Change	HN/Del Impact? (Change to Template, Frequency, FTP Folder)
UM Program	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_AnnualYYYY_UMP" to "2_UMRPT_AORPT_HN_AnnualYYYY_UMP"	Yes
UM Evaluation (Previous Year)	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_AnnualYYYY_UME" to "2_UMRPT_AORPT_HN_AnnualYYYY_UME"	Yes
UM Work Plan Current Year (Initial)	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_AnnualYYYY_UMCY" to "2_UMRPT_AORPT_HN_AnnualYYYY_UMCY"	Yes
UM Work Plan (ICE)	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_SemiAnnualYYYY_UMCY" to "2_UMRPT_AORPT_HN_SemiAnnualYYYY_UMCY"	Yes
UM Committee Meeting Minutes	1	12/4/2017	Naming Convention changed from "1_UMRPT_HN_SemiAnnuallYYYY_Minutes" to "2_UMRPT_AORPT_HN_SemiAnnuallYYYY_Minutes"	Yes
Credentialing Annual Universe	1	12/4/2017	Description changed to clarify the universe must include "all currently contracted providers at the time the report is run."	No
Customer Service Call Log Universe	1	12/4/2017	Report Frequency changed from Monthly to Quarterly	No - Announced on 11/7/17
Call Center Statistics	1	12/4/2017	Template changed to add Submitter Name, correct threshold languages for each LOB	Yes
Health Network Newly Contracted Provider Training Report	1	12/4/2017	Monitoring Department changed from "PN" to "HNR"	No
Medical Loss Ratio	1	12/4/2017	Report Frequency of Interim Report changed from "Waived" to "January - June due August 15" Naming Convention changed to add Interim Report	Yes
Utlization Report - ASH	1	12/4/2017	New report (American Specialty Health/ASH only)	No - Implemented in 2017
HN Dashboard	1	12/4/2017	Template changed to add Transportation Calls (announced 10/9/17) Naming Convention changed from "1_HMRPT_HN_MMYYYY_Dashboard" to "2_HMRPT_CSRPT_HN_MMYYYY_Dashboard"	Yes
OneCare Connect Care Transition Log	1	12/4/2017	Template changed to update column headers	No - Announced 7/3/17
Implementation Audit Bundles	1	12/4/2017	Newly added to grid	No - Announced in 2016
DHCS NMT/NEMT Report - Kaiser	1	12/4/2017	New report (Kaiser only)	Yes
Beacon Reports	1	12/4/2017	Removed all Beacon reports	No
Magellan Reports	1	12/4/2017	Added final submission date for Magellan Medi-Cal reports	Yes (Magellan only)
Provider Directory Universe	2	1/2/2018	Report Frequency corrected from the 7th to the 10th Template changed to add "Contact Information" and "Medical Group Affiliation" fields Instructions updated to reflect template changes	Yes
Medical Loss Ratio	2	1/2/2018	Report Frequency and Naming Convention corrected to include interim report.	No - Existing requirement
Nurse Advice Line Call Log	2	1/2/2018	Line of Business changed from "All" to "OneCare, OneCare Connect"	Yes
QI Work Plan (ICE)	3		Updated ICE template	No - Announced 1/29/18
UM Work Plan (ICE)	3		Updated ICE template	No - Announced 1/29/18

Back to Agenda

Report Name	Release Number	Date of Release	Change	HN/Del Impact? (Change to Template, Frequency, FTP Folder)

Back to Agenda

Policy #:	HH.1108
Title:	**State Hearing Process and Procedures**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	~~11/1999~~11/01/1999
~~Last Review Date:~~	~~07/01/17~~02/07/19
~~Last~~ Revis~~ion~~ed Date:	~~07/01/17~~TBD

I. PURPOSE

This policy defines CalOptima's process, role, and responsibilities in ensuring a Member's right to access the State Hearing process.

II. POLICY

A. A Member ~~seeking to appeal denials, limitations~~, or ~~modifications to Covered Services by CalOptima~~a Member's Authorized Representative or ~~its Health Networks may do so through~~Provider acting on behalf of the ~~Appeal Process established by CalOptima.~~Member and with his or her written consent, has the right to request a State Hearing when a claim for medical assistance is delayed, modified, denied, or discontinued and or not acted upon with reasonable promptness. Once the CalOptima-level Appeal Process has been exhausted ~~or should have been exhausted,~~ a Member may request a State Hearing.

B. CalOptima is not involved in the Medi-Cal eligibility process, and shall not participate in State Hearings related to eligibility determinations. However, as the Medi-Cal managed care plan in Orange County, CalOptima shall participate in State Hearings that address medical service denials to Members.

C. CalOptima shall provide a Member with a thorough explanation of the right to request a State Hearing, and shall assist the Member, upon request, in filing his or her request for a State Hearing. CalOptima shall provide any and all information that can be of assistance to the Member in preparing for the State Hearing, including both regulations and evidence, which might be favorable to the Member's case.

D. A Member shall file a request for a State Hearing with the Department of Social Services (DSS) within one hundred and twenty (120) calendar days after the date of the Notice of Appeal Resolution or Appeal resolution timeframe has exhausted.

E. CalOptima shall not unlawfully discriminate against a Member for requesting a State Hearing.

F. The parties to a State Hearing include CalOptima, with the assistance of the Member's Health Network, as well as the Member and the Member's Authorized Representative or representative of a

deceased Member's estate. CalOptima shall act on its own behalf as the public agency that administers the Medi-Cal program in Orange County, and may represent its Health Networks, if no other representation is provided. Whenever the issue pertains to a Health Network's action or inaction, representatives from the involved Health Network are requested to attend the hearing.

G. When appropriate, CalOptima shall grant Aid Paid Pending, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, until a State Hearing decision is rendered.

H. The DSS will adopt a hearing decision within three (3) working days of the date of the request (for Expedited Hearing only).

~~H.~~I. The DSS will adopt a hearing decision within ninety (90) calendar days after the earliest filing date, unless the Member waives the normal timeline for a decision to be rendered.

~~I.~~J. CalOptima shall maintain all State Hearings case files involving a Member for at least ten (10) years after the resolution of the Appeal.

~~J.~~K. CalOptima shall monitor the number, type, and resolution of State Hearings, and utilize this information to improve its and its Health Networks' provision of service.

III. PROCEDURE

A. CalOptima shall communicate the Appeal Process and the Member's statutory right to a State Hearing, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, to a Member in writing. This disclosure shall be included in the CalOptima Member Handbook, in accordance with CalOptima Policy DD.2005: Member Handbook Requirements and an explanation of the right to request a State Hearing shall be provided by the CalOptima Customer Service Department, by telephone, as requested by the Member.

~~B. To request a State Hearing, a Member may:~~

B. A Member, or a Member's Authorized Representative or Provider acting on behalf of the Member and with the Member's written consent, may request a State Hearing for a review of an adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of service(s) by:

1. Write to:

   Department of Social Services
   State Hearings Division
   P. O. Box 944243, M.S. 9-17-37
   Sacramento, CA 94244;

2. Call 1-800-952-5253 or, for TDD only, 1-800-952-8349;
   Facsimile 1-916-651-5210 or 916-651-2789; or

3. Present him or herself to the Department of Social Services at:

   744 P Street
   Sacramento, CA 95814

C. State Hearing Process

1. The DSS Administrative Adjudications Division (AAD) will send a written acknowledgment of the hearing request to the Member, the Member's Authorized Representative (to include completed an authorization for release of protected health information (PHI), Durable Power of Attorney, Legal Guardianship, Conservatorship, and or Executor of Estate) or Provider (with a completed – Member confirmation of Appeal) acting on behalf of the Member and with the Member's written consent, and to CalOptima Grievance and Appeals Resolution Services (GARS).

2. The DSS Operations Support Bureau (OSB) shall schedule the hearing, and send written notification that includes the time and location of the hearing to all hearing parties, no later than ten (10) calendar days prior to the hearing.

~~C.~~a. CalOptima shall notify DSS if an interpreter may be necessary at the hearing and the DSS Staff Development Training Bureau (SDTB) is responsible for making arrangements for interpreters to be present at the hearing, if appropriate.

~~D.~~3. CalOptima GARS shall be responsible for the administrative coordination of CalOptima's responsibilities in the State Hearing process.

D. State Hearing Postponement, Withdrawal and No-show Process:

~~E.~~1. Hearing parties may request a postponement of a scheduled hearing to a subsequent date not more than thirty (30) calendar days beyond the original hearing date. Postponements may be granted for good cause before the hearing date, at the discretion of the DSS State Hearing Support Section (SHSS), or by the hearing judge on the hearing date. Good cause is established if:

~~1.~~a. The Member has a death in the family, a personal illness or injury, a sudden and unexpected emergency that prevents the Member or Authorized Representative from appearing, or a conflicting court appearance that cannot be postponed; or

~~2.~~b. CalOptima does not make a position statement available to the Member at least two (2) business days prior to the date of the scheduled hearing, or modifies the position statement.

2. ~~A Member~~A Member, Member's Authorized Representative, or Provider, on behalf of the Member with

~~F.~~ the Member's written consent, may also notify DSS of his or her wish to withdraw the hearing request, or to withdraw specific issues identified in the hearing request, at any time prior to a signed decision. If a Member notifies CalOptima of his or her intent to withdraw the hearing request, CalOptima shall assist the Member by providing the phone number to DSS, connecting the Member to DSS via a conference call, or by mailing the Member a Withdrawal of Request for State Hearing form.

~~G.~~3. If the Member or the Member's Authorized Representative fails to appear at the scheduled State Hearing without good cause, the request shall be considered abandoned. If the Member does not request a reinstatement within ten (10) calendar days from the scheduled hearing date, and present good cause, DSS will notify the Member, in writing, as to the specific reasons for the decision or dismissal, and the right to request a rehearing.

E. CalOptima's Pre Hearing Process:

~~H.~~1. A CalOptima representative shall research information on the issues presented, contact the Member for clarification of any part of the hearing request that does not clearly set forth the Member's basis for appeal, and make efforts to bring all parties to an agreement on a possible resolution of the matter prior to the hearing.

~~I.~~2. If a CalOptima representative concludes CalOptima's action was correct, the CalOptima representative shall contact the Member to inquire if the Member plans to attend the hearing, determine if there are any further contentions which the Member will attempt to raise at the hearing and provide information that may be of assistance to the Member as described in Section II.C. of this policy.

~~J.~~3. CalOptima GARS shall determine the issues, review the applicable statutes, regulations, and policies in light of the evidence existing in the case record, and, prior to the hearing, prepare a written position statement, consulting with Legal Affairs as appropriate.

~~K.~~4. Issues at the hearing shall be limited to those reasonably related to the request for hearing, or other issues identified by either the involved agency or the claimant, and jointly agreed upon for discussion prior to or at the State Hearing.

5. Except with regard to an expedited State Hearing, CalOptima shall submit a position statement that summarizes the facts of the case, the regulatory justification of CalOptima's action, any documentary evidence, and recommendation(s) for resolution. The position statement shall be submitted to the DHCS Ombudsman Office, the DSS AAD, the County Hearing Unit and the Member by certified mail at least two (2) business days prior to the hearing date.

~~L.~~6. A Member and the Authorized Representative and/or Provider may submit a position statement, but are not required to do so, and are not required to make the position statement available to any other hearing party prior to the hearing. If CalOptima does not make the position statement available at least two (2) business days prior to the hearing date, or if CalOptima modifies the position statement in a way that substantively revises the statement after providing the statement to the Member, the hearing shall be postponed upon the request of the Member conditioned upon the waiver of any decision deadlines.

7. ~~With~~In regard to an expedited State Hearing, within two (2) business days of being notified by DHCS or DSS that a Member has filed a request for a State Hearing that meets the criteria for expedited resolution, CalOptima shall deliver directly to the designated/appropriate DSS Administrative Law Judge (ALJ) all information and documents that either support, or that CalOptima considered in connection with, the action that is the subject of the expedited State Hearing. This includes, but is not limited to~~, copies~~:

a. Copies of the relevant prior authorization and Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA~~), plus any~~).

b. Any pertinent Notice of Appeal Resolution (NAR) notice. If the NABD/NOA or NAR are not in English, CalOptima shall provide fully translated copies to DSS, along with copies of the original NABD and NAR.

~~M.~~c. One (1) or more CalOptima or Health Network staff with knowledge of the Member's condition and the reason(s) for the action that is the subject of the expedited State Hearing shall be available by phone during the scheduled State Hearing.

F. State Hearing Phase

~~N.~~1. During the State Hearing process, CalOptima or a Health Network ~~must~~ shall authorize or provide the disputed ~~Covered Services~~services promptly, and as expeditiously as the Member's health condition requires~~.~~, but no later than seventy-two (72) hours from the date CalOptima received the decision, if the Covered Services are not furnished while the ~~appeal~~Appeal is pending and CalOptima or a Health Network ~~reverses a decision to deny, limit, or delay Covered Services~~from the date it receives notice reversing the determination. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

~~O.~~2. At the hearing, CalOptima will be responsible for the presentation of CalOptima's case. The presentation shall include:

~~1.~~a. Summary of the written position statement;

~~2.~~b. Examining witnesses;

~~3.~~c. Cross-examining the Member and the Member's witnesses;

~~4.~~d. Responding to any questions from the Member or the Member's Authorized Representative, or the ALJ concerning the case; and

~~5.~~e. Having the case record available at the hearing.

~~P.~~f. Merits of a pending State Hearing shall not be discussed between the ALJ and a hearing party outside the presence of the other party.

G. Hearing Decision(s)

~~Q.~~1. After a hearing, the ALJ will submit a proposed decision for review by the Chief ALJ or Department of Health Care Services (DHCS) Director, who will adopt a final decision. The final decision will be mailed to both the Member and CalOptima, and will include notice of the right to judicial review or rehearing. Once rendered, the hearing decision shall be considered the final and only notice to the Member on the resolution of the Member's hearing issue.

~~R.~~ A hearing party may request, in writing, another hearing with the DSS AAD no later than thirty (30) calendar days after the hearing party receives the released decision copy.

~~S.~~2. Upon receipt of the hearing decision, CalOptima or the Health Network shall initiate action to comply with the decision, even if a rehearing is requested.

~~1.~~3. If the decision is made wholly or partially in favor of the Member, CalOptima shall submit a ~~———~~compliance report to the AAD, using the County Report of Compliance form, when requested ~~———~~by AAD or DSS.

~~2.~~ If the decision is made wholly or partially in favor of the Member, CalOptima or a Health Network shall authorize or provide the disputed ~~services~~Services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours if the Covered Services are not furnished while the Appeal is pending and CalOptima or a Health Network from the date ~~of~~ it receives notice reversing the determination.

4. ~~If the decision~~ CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

~~3.~~5. If the decision is decided in favor of CalOptima, in cases in which Aid Paid Pending was requested, CalOptima shall terminate any authorization of the continuance of aid. No additional notification to the Member is required.

~~T.~~6. CalOptima's failure to comply with a decision may result in action by DHCS to ensure compliance. In such cases, the Member shall be permitted to request a new State Hearing concerning his or her dissatisfaction with Compliance Issues and Compliance-Related Issues.

~~U.~~7. A Member may contact the DSS verbally, or in writing, if he or she is dissatisfied with the compliance. There is no right to a State Hearing if the request for a hearing is based solely on a compliance issue, since the substantive issues have already been resolved, and the remaining issue is one of enforcement only.

~~V.~~8. CalOptima shall maintain a database containing information on the number of State Hearing requests filed, scheduled, and resolved, indicating hearing issue, hearing dates, Health Network involved, and Member information.

IV. ATTACHMENT(S)

A. Withdrawal of Request for State Fair Hearing
B. County Report of Compliance
C. Notice of Appeal Resolution

V. REFERENCES

A. California Department of Social Services Manual Letter No. CFC-07-01, Regulation 22-073
B. California Welfare and Institutions Code, §10950 through 10967
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy DD.2005: Member Handbook Requirements
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510 Appeal Process for Decisions Regarding Care and Services
~~F.~~G. CalOptima Policy HH.1102: CalOptima Member Complaint
~~G.~~H. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~H.~~I. Title 22, California Code of Regulations (C.C.R.), §50951 through 50955
~~I.~~J. Title 42, Code of Federal Regulations (C.F.R.), §§ 438.404(b)(3), 438.404(c)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 06/10/15: Department of Health Care Services
C. 01/05/10: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	11/1999	AA.1203	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2007	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2010	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	10/01/2011	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2013	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2014	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	04/01/2015	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	06/01/2016	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2017	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	TBD	HH.1108	State Hearing Process and Procedures	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination (NABD)	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a aa Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or California Department of Social Services pursuant to Regulation Sections 22-085 and 22-101 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.
Complaint	An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
Compliance Issue	An allegation by the claimant that the county has failed to abide by a state hearing decision concerning issues clearly resolved in the order where the county did not have to make further determinations regarding the claimant's eligibility or amount of benefits.
Compliance Related Issues	Issues which were not resolved in the prior state hearing decision or resulted from the prior hearing decision requiring the county to make further determinations regarding the claimant's eligibility or amount of benefits.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Grievance	An oral or written expression of dissatisfaction about any aspect of the CalOptima program, other than an Adverse Benefit Determination.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notice Adverse Benefit Determination (NABD)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.
Notice of Action (NOA)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.

Term	Definition
Notice of Appeal Resolution (NAR)	A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overtu;rned or upheld.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.

Policy #:	HH.1108
Title:	**State Hearing Process and Procedures**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	11/01/1999
Revised Date:	TBD

I. PURPOSE

This policy defines CalOptima's process, role, and responsibilities in ensuring a Member's right to access the State Hearing process.

II. POLICY

A. A Member, or a Member's Authorized Representative or Provider acting on behalf of the Member and with his or her written consent, has the right to request a State Hearing when a claim for medical assistance is delayed, modified, denied, or discontinued and or not acted upon with reasonable promptness. Once the CalOptima-level Appeal Process has been exhausted a Member may request a State Hearing.

B. CalOptima is not involved in the Medi-Cal eligibility process, and shall not participate in State Hearings related to eligibility determinations. However, as the Medi-Cal managed care plan in Orange County, CalOptima shall participate in State Hearings that address medical service denials to Members.

C. CalOptima shall provide a Member with a thorough explanation of the right to request a State Hearing, and shall assist the Member, upon request, in filing his or her request for a State Hearing. CalOptima shall provide any and all information that can be of assistance to the Member in preparing for the State Hearing, including both regulations and evidence, which might be favorable to the Member's case.

D. A Member shall file a request for a State Hearing with the Department of Social Services (DSS) within one hundred and twenty (120) calendar days after the date of the Notice of Appeal Resolution or Appeal resolution timeframe has exhausted.

E. CalOptima shall not unlawfully discriminate against a Member for requesting a State Hearing.

F. The parties to a State Hearing include CalOptima, with the assistance of the Member's Health Network, as well as the Member and the Member's Authorized Representative or representative of a deceased Member's estate. CalOptima shall act on its own behalf as the public agency that administers the Medi-Cal program in Orange County, and may represent its Health Networks, if no other representation is provided. Whenever the issue pertains to a Health Network's action or inaction, representatives from the involved Health Network are requested to attend the hearing.

G. When appropriate, CalOptima shall grant Aid Paid Pending, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, until a State Hearing decision is rendered.

H. The DSS will adopt a hearing decision within three (3) working days of the date of the request (for Expedited Hearing only).

I. The DSS will adopt a hearing decision within ninety (90) calendar days after the earliest filing date, unless the Member waives the normal timeline for a decision to be rendered.

J. CalOptima shall maintain all State Hearings case files involving a Member for at least ten (10) years after the resolution of the Appeal.

K. CalOptima shall monitor the number, type, and resolution of State Hearings, and utilize this information to improve its and its Health Networks' provision of service.

III. PROCEDURE

A. CalOptima shall communicate the Appeal Process and the Member's statutory right to a State Hearing, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, to a Member in writing. This disclosure shall be included in the CalOptima Member Handbook, in accordance with CalOptima Policy DD.2005: Member Handbook Requirements and an explanation of the right to request a State Hearing shall be provided by the CalOptima Customer Service Department, by telephone, as requested by the Member.

B. A Member, or a Member's Authorized Representative or Provider acting on behalf of the Member and with the Member's written consent, may request a State Hearing for a review of an adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of service(s) by:

1. Write to:

   Department of Social Services
   State Hearings Division
   P. O. Box 944243, M.S. 9-17-37
   Sacramento, CA 94244;

2. Call 1-800-952-5253 or, for TDD only, 1-800-952-8349;
   Facsimile 1-916-651-5210 or 916-651-2789; or

3. Present him or herself to the Department of Social Services at:

   744 P Street
   Sacramento, CA 95814

C. State Hearing Process

1. The DSS Administrative Adjudications Division (AAD) will send a written acknowledgment of the hearing request to the Member, the Member's Authorized Representative (to include completed an authorization for release of protected health information (PHI), Durable Power of Attorney, Legal Guardianship, Conservatorship, and or Executor of Estate) or Provider (with a completed – Member confirmation of Appeal) acting on behalf of the Member and with the Member's written consent, and to CalOptima Grievance and Appeals Resolution Services (GARS).

2. The DSS Operations Support Bureau (OSB) shall schedule the hearing, and send written notification that includes the time and location of the hearing to all hearing parties, no later than ten (10) calendar days prior to the hearing.

    a. CalOptima shall notify DSS if an interpreter may be necessary at the hearing and the DSS Staff Development Training Bureau (SDTB) is responsible for making arrangements for interpreters to be present at the hearing, if appropriate.

3. CalOptima GARS shall be responsible for the administrative coordination of CalOptima's responsibilities in the State Hearing process.

D. State Hearing Postponement, Withdrawal and No-show Process:

1. Hearing parties may request a postponement of a scheduled hearing to a subsequent date not more than thirty (30) calendar days beyond the original hearing date. Postponements may be granted for good cause before the hearing date, at the discretion of the DSS State Hearing Support Section (SHSS), or by the hearing judge on the hearing date. Good cause is established if:

    a. The Member has a death in the family, a personal illness or injury, a sudden and unexpected emergency that prevents the Member or Authorized Representative from appearing, or a conflicting court appearance that cannot be postponed; or

    b. CalOptima does not make a position statement available to the Member at least two (2) business days prior to the date of the scheduled hearing, or modifies the position statement.

2. A Member, Member's Authorized Representative, or Provider, on behalf of the Member with the Member's written consent, may also notify DSS of his or her wish to withdraw the hearing request, or to withdraw specific issues identified in the hearing request, at any time prior to a signed decision. If a Member notifies CalOptima of his or her intent to withdraw the hearing request, CalOptima shall assist the Member by providing the phone number to DSS, connecting the Member to DSS via a conference call, or by mailing the Member a Withdrawal of Request for State Hearing form.

3. If the Member or the Member's Authorized Representative fails to appear at the scheduled State Hearing without good cause, the request shall be considered abandoned. If the Member does not request a reinstatement within ten (10) calendar days from the scheduled hearing date, and present good cause, DSS will notify the Member, in writing, as to the specific reasons for the decision or dismissal, and the right to request a rehearing.

E. CalOptima's Pre Hearing Process:

1. A CalOptima representative shall research information on the issues presented, contact the Member for clarification of any part of the hearing request that does not clearly set forth the Member's basis for appeal, and make efforts to bring all parties to an agreement on a possible resolution of the matter prior to the hearing.

2. If a CalOptima representative concludes CalOptima's action was correct, the CalOptima representative shall contact the Member to inquire if the Member plans to attend the hearing, determine if there are any further contentions which the Member will attempt to raise at the hearing and provide information that may be of assistance to the Member as described in Section II.C. of this policy.

3. CalOptima GARS shall determine the issues, review the applicable statutes, regulations, and policies in light of the evidence existing in the case record, and, prior to the hearing, prepare a written position statement, consulting with Legal Affairs as appropriate.

4. Issues at the hearing shall be limited to those reasonably related to the request for hearing, or other issues identified by either the involved agency or the claimant, and jointly agreed upon for discussion prior to or at the State Hearing.

5. Except with regard to an expedited State Hearing, CalOptima shall submit a position statement that summarizes the facts of the case, the regulatory justification of CalOptima's action, any documentary evidence, and recommendation(s) for resolution. The position statement shall be submitted to the DHCS Ombudsman Office, the DSS AAD, the County Hearing Unit and the Member by certified mail at least two (2) business days prior to the hearing date.

6. A Member and the Authorized Representative and/or Provider may submit a position statement, but are not required to do so, and are not required to make the position statement available to any other hearing party prior to the hearing. If CalOptima does not make the position statement available at least two (2) business days prior to the hearing date, or if CalOptima modifies the position statement in a way that substantively revises the statement after providing the statement to the Member, the hearing shall be postponed upon the request of the Member conditioned upon the waiver of any decision deadlines.

7. In regard to an expedited State Hearing, within two (2) business days of being notified by DHCS or DSS that a Member has filed a request for a State Hearing that meets the criteria for expedited resolution, CalOptima shall deliver directly to the designated/appropriate DSS Administrative Law Judge (ALJ) all information and documents that either support, or that CalOptima considered in connection with, the action that is the subject of the expedited State Hearing. This includes, but is not limited to:

   a. Copies of the relevant prior authorization and Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA).

   b. Any pertinent Notice of Appeal Resolution (NAR) notice. If the NABD/NOA or NAR are not in English, CalOptima shall provide fully translated copies to DSS, along with copies of the original NABD and NAR.

   c. One (1) or more CalOptima or Health Network staff with knowledge of the Member's condition and the reason(s) for the action that is the subject of the expedited State Hearing shall be available by phone during the scheduled State Hearing.

F. State Hearing Phase

1. During the State Hearing process, CalOptima or a Health Network shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date CalOptima received the decision, if the Covered Services are not furnished while the Appeal is pending and CalOptima or a Health Network from the date it receives notice reversing the determination. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

2. At the hearing, CalOptima will be responsible for the presentation of CalOptima's case. The presentation shall include:

    a. Summary of the written position statement;

    b. Examining witnesses;

    c. Cross-examining the Member and the Member's witnesses;

    d. Responding to any questions from the Member or the Member's Authorized Representative, or the ALJ concerning the case; and

    e. Having the case record available at the hearing.

    f. Merits of a pending State Hearing shall not be discussed between the ALJ and a hearing party outside the presence of the other party.

G. Hearing Decision(s)

1. After a hearing, the ALJ will submit a proposed decision for review by the Chief ALJ or Department of Health Care Services (DHCS) Director, who will adopt a final decision. The final decision will be mailed to both the Member and CalOptima, and will include notice of the right to judicial review or rehearing. Once rendered, the hearing decision shall be considered the final and only notice to the Member on the resolution of the Member's hearing issue.

2. A hearing party may request, in writing, another hearing with the DSS AAD no later than thirty (30) calendar days after the hearing party receives the released decision copy. Upon receipt of the hearing decision, CalOptima or the Health Network shall initiate action to comply with the decision, even if a rehearing is requested.

3. If the decision is made wholly or partially in favor of the Member, CalOptima shall submit a compliance report to the AAD, using the County Report of Compliance form, when requested by AAD or DSS.

4. If the decision is made wholly or partially in favor of the Member, CalOptima or a Health Network shall authorize or provide the disputed Services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours if the Covered Services are not furnished while the Appeal is pending and CalOptima or a Health Network from the date it receives notice reversing the determination. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal was pending.

5. If the decision is decided in favor of CalOptima, in cases in which Aid Paid Pending was requested, CalOptima shall terminate any authorization of the continuance of aid. No additional notification to the Member is required.

6. CalOptima's failure to comply with a decision may result in action by DHCS to ensure compliance. In such cases, the Member shall be permitted to request a new State Hearing concerning his or her dissatisfaction with Compliance Issues and Compliance-Related Issues.

7. A Member may contact the DSS verbally, or in writing, if he or she is dissatisfied with the compliance. There is no right to a State Hearing if the request for a hearing is based solely on a

compliance issue, since the substantive issues have already been resolved, and the remaining issue is one of enforcement only.

8. CalOptima shall maintain a database containing information on the number of State Hearing requests filed, scheduled, and resolved, indicating hearing issue, hearing dates, Health Network involved, and Member information.

IV. ATTACHMENT(S)

A. Withdrawal of Request for State Fair Hearing
B. County Report of Compliance
C. Notice of Appeal Resolution

V. REFERENCES

A. California Department of Social Services Manual Letter No. CFC-07-01, Regulation 22-073
B. California Welfare and Institutions Code, §10950 through 10967
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Policy DD.2005: Member Handbook Requirements
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510 Appeal Process for Decisions Regarding Care and Services
G. CalOptima Policy HH.1102: CalOptima Member Complaint
H. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
I. Title 22, California Code of Regulations (C.C.R.), §50951 through 50955
J. Title 42, Code of Federal Regulations (C.F.R.), §§ 438.404(b)(3), 438.404(c)(3)

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 06/10/15: Department of Health Care Services
C. 01/05/10: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/1999	AA.1203	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2007	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2010	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	10/01/2011	HH.1108	State Hearing Process and Procedures	Medi-Cal

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Revised	01/01/2014	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	04/01/2015	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	06/01/2016	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2017	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	TBD	HH.1108	State Hearing Process and Procedures	Medi-Cal

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IX. GLOSSARY

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State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.

☐ **WITHDRAWAL** ☐ **CONDITIONAL WITHDRAWALS**

OF
REQUEST FOR HEARING

Case Name: _____ County Case No: _____

State Hearing No: _____ Filing Date: _____

County: _____ Hearing Date: _____

Hearing Time: _____

I, _____, the undersigned do hereby:

☐ Withdraw my request for a state hearing before the State Department of Social Services. I understand that by withdrawing my request, I lose my right to a hearing on that request. I also understand that by withdrawing my request for hearing, aid which has been paid because of the request will stop without further notice. I may, however, file a new hearing request raising the identical issue provided that the new request is timely per Manual of Policies and Procedures Section 22-009.

☐ Conditionally withdraw my request for a state hearing before the State Department of Social Services. I understand that by conditionally withdrawing my request for hearing, aid which has been paid because of the hearing request will stop without further notice. I understand that the county will issue a redetermination notice within 30 days and that I must request a hearing within **90 DAYS** of the county's notice if I am not satisfied with the county's reconsideration of my case. Upon such renewal, I shall have the same rights I would have had if I had not signed this conditional withdrawal.

NOTE: A conditional withdrawal must provide that the actions of both parties will be completed within 30 days.

The reasons for or conditions of this withdrawal are: _____

_____

_____

_____

_____

_____

Signed

_____
(County Representative) (Date)

_____
(County Address)

_____
(City) (Zip Code)

_____
(Telephone Number)

Signed

_____
(Claimant) (Date)

_____
(Address)

_____
(City) (Zip Code)

_____
(Telephone Number)

NOTE: A Conditional Withdrawal must also be signed by a County Representative or it is invalid.

DPA 315 (7/99)

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COUNTY REPORT OF COMPLIANCE TRANSMITTAL

Due within 30 days of receipt of decision

COUNTY	DATE

NAME ADDRESS *(if changed)*	STATE HEARING #	ADOPT DATE	COMPLIANCE NOTIFICATION DATE	EFFECTIVE DATE	CODE(S) OR BRIEF STATEMENT

I certify that the above compliance information is true and correct to the best of my knowledge.

NAME	PHONE NUMBER	DATE

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COMPLIANCE CODE OPTIONS

- Use program code (letter) for each program in which a compliance action is required.
- Use one or more action codes (number) for each program code.

PROGRAM CODES:

A. AFDC

B. FS

C. Medi-Cal

D. IHSS

E. AFDC/FC

F. OTHER: List Program

ACTION CODES:

1. Action rescinded –Benefits determined & issued as eligible.
2. Action rescinded – Benefits not determined or issued due to lack of information. Admin Close.
3. Entitlement received as aid pending, (APP).
4. No eligibility for retroactive benefits found.
5. O/P or O/I reduced / cancelled as ordered.
6. Retro benefits reduced or not issued due to balancing against existing O/P, O/I.
7. SOC changed as ordered.
8. County has offered assistance to the claimant in obtaining reimbursement for any Medi-Cal covered expenses incurred.
9. Delayed Compliance (Brief explanation) Wait for followup transmittal.
10. OTHER: (Brief explanation)

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Reading Level 5.6, Powers, Sumner, Kearl (Gunning Fog), April 27, 2017 JH
Reviewed by VC 5-3-17
Reviewed by MKC 5-4-17
Revised Readability Level 5.6 Powers, Sumner, Kearl (Gunning Fog) by MKC on 5-4-17

"Uphold"

NOTICE OF APPEAL RESOLUTION
About Your Adverse Benefit Determination

[Date]

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

[Treating Provider's Name-Optional]
[Address]
[City, State Zip]

Identification Number

RE: [service requested]

You [or Name of requesting provider or authorized representative on your behalf,] [have or has] appealed the [denial, delay, modification, or termination] of [service requested].

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on [date] and has decided to uphold the decision. This request is denied because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

On [Date] at [Time] you were contacted and informed of the decision; or a message was left informing you of the decision; or a message was left asking for a call back>.

You may request copies of all documents and records related to this decision free of charge. If you would like to obtain a copy of the actual benefit terms, guidelines, procedures, or other criteria on which the decision was based, please call [Grievance Resolution Services Staff Name] at [telephone number].

If you need help reading this letter or have any questions, please call, [Grievance Resolution Services Staff Name], at [telephone number].

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where to go to get help, including free legal help. You are encouraged to submit written comments, documents, or any other information relevant to your appeal. The enclosure also tells you the deadlines for pursuing an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" is available to assist you with any questions you may have with this notice. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us toll free at 1-888-587-8088.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

Grievance and Appeals

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

Back to Agenda

Policy #:	GG.1510
Title:	**Appeal Process ~~for Decisions Regarding Care and Services~~**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/95
~~Last Review Date:~~	~~07/01/17~~
~~Last~~ Revised Date:	~~07/01/17~~TBD

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves ~~pre-service, post-service, expedited and external~~ Utilization Management (UM) ~~Appeals, in accordance with applicable statutory, regulatory, and contractual requirements~~appeals, including Adverse Benefit Determinations involving the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.

II. POLICY

A. CalOptima shall establish and maintain an Appeal Process pursuant to ~~which a~~applicable statutory, regulatory and contractual requirements.

~~A.~~B. A Member, or a Member's Authorized Representative ~~may submit~~, or Provider acting on behalf of the Member, and with the Member's written consent, has the right to file an Appeal ~~for review and Resolution~~in the timeframes set forth in this policy.

~~B.~~C. CalOptima's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

~~C.~~D. CalOptima shall assist a Member requiring assistance with filing an Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs and in accordance with Section III.G.1 of this Policy.

~~D.~~E. CalOptima shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

~~E.~~ CalOptima shall ~~ensure that the person making the final decision on the Appeal did not participate in any decisions related to the Appeal.~~

F. ~~CalOptima shall~~ refer all ~~Grievances~~Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

G. CalOptima and a Health Network shall inform a Member, during the Appeal Process, of their right to request a State Hearing after the internal Appeal Process has been exhausted or should have been exhausted, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures~~,~~ and GG.1507: Notification Requirements for Covered

Services Requiring Prior Authorization~~, and GG.1510: Appeal Process for Decisions Regarding Care and Services~~.

H. Neither CalOptima ~~and a Health Network~~, nor any of its Health Networks, Practitioners, or other Providers shall ~~not~~ discriminate ~~or retaliate~~ against ~~any~~a Member~~-~~, a Member's Authorized Representative, or a Provider on the grounds that ~~such Member~~he or she filed an Appeal~~, in accordance with CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations~~.

~~J.~~I. ~~A Provider or a Member shall have the right to Appeal the UM decision. Upon receipt of a~~A Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) sent by CalOptima or a Health Network notifying a Provider or a Member of a CalOptima or Health Network UM decision to delay, deny, modify, or recommend an alternative option to a requested service~~. The UM Appeal shall be a separate process from the Provider Complaint, Member Complaint, Member State Fair Hearing, or claims resubmission processes as specified in CalOptima Policies HH.1101: CalOptima Provider Complaint, HH.1102: CalOptima Member Complaint, HH.1108: State Hearing Process and Procedures, and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.~~, shall inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.

J. The Member UM Appeal process set forth in this policy is a separate process from the Member Grievance Process in CalOptima Policy HH.1102: Member Grievance and Member State Hearing Process in CalOptima Policy HH.1108: State Hearing Process and Procedures. It is also separate from Provider processes in CalOptima Policy HH.1101: CalOptima Provider Complaint.

K. CalOptima shall give a Member, a Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and law in support of the Appeal. ~~In the case of an Appeal subject to an expedited review,~~ CalOptima and a Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Appeals.

L. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Appeals process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

M. A Member may be represented by anyone they choose during the Appeal process, including ~~an attorney. For purposes of this policy, a Member representative must be authorized by the Member, in writing, to represent the Member in the Appeal process, or the representative must submit a copy of a durable power of attorney for Health Care or similar legal appointment of representative document; or otherwise be recognized under California law as a legal representative of the Member.~~a legal representative.

~~N. CalOptima or a Health Network shall inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.~~

~~O.~~N. The Member has the right to request an Appeal in the event that CalOptima or a Health Network fails to issue a NABD/NOA within the required time frame, ~~it~~which shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

~~P.~~O. CalOptima shall provide, upon request by the Member ~~or,~~ his or her Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, before and during the Appeals process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals process. CalOptima shall provide records ~~to the Member or his or her Authorized Representative~~ at no cost.

~~Q.~~P. CalOptima shall ensure that the person reviewing the UM Appeal was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.

~~R.~~Q. CalOptima shall ensure that for UM Appeals ~~involving Medical Necessity decisions,~~ the person making the final decision for the proposed resolution of an Appeal has ~~not~~neither participated in any prior decisions related to the Appeal, ~~and~~nor is a ~~health care professional with~~subordinate of someone who has participated in a prior decision and has clinical expertise ~~that may be demonstrated by appropriate specialty training, experience or certification by the American Board of Medical specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions~~ in treating ~~a~~the Member's condition or disease~~.~~ if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity; and

2. Any Appeal involving clinical issues.

~~S.~~R. A Member shall receive the continuation of the benefit until one (1) of the following occurs:

1. Member withdraws the Appeal;

2. Ten (10) days pass after CalOptima mails the NABD/NOA;

3. Grievance and Appeals Resolution Services (GARS) issues an Appeal decision adverse to the Member; and

4. The time period or service limits of a previously authorized service has been met.

~~S.~~T. A Provider, with the Member's written consent, may request a UM Appeal on behalf of the Member, for services rendered to that ~~-~~CalOptima Member, by submitting a written request to CalOptima within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network, in accordance with the provisions of this policy.

~~T.~~U. Upon notice of a CalOptima decision to deny an authorization request, a Member ~~or a Provider may request an expedited UM Appeal~~, a Member's Authorized Representative, or a Provider, acting on behalf of the Member with the Member's written consent, may request an expedited UM Appeal when it is determined or the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

~~V. CalOptima may extend the timeframe to resolve the Appeal by up to fourteen (14) calendar days at the request of the Member or if there is a need for additional information and how the delay is in the Member's best interest.~~

~~W. For any extensions not requested by the Member, CalOptima must provide the Member with written notice of the reason for the delay and the right to file a Grievance within two (2) calendar days from the oral notification of the extension.~~

~~W.~~V. All medical Appeals are referred to the Chief Medical Officer (CMO), or to his or her Designee, who has the authority to require corrective action, and did not make the initial utilization management decision.

W. CalOptima and a Health Network shall provide the CalOptima Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract.

~~Y.~~X. CalOptima shall provide language assistance to Members, by CalOptima staff ~~for Threshold Languages and~~ or language line ~~interpretation~~interpreter services, ~~as needed,~~for Threshold Languages to register and resolve ~~Grievances in all other languages.~~Appeals.

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make complaint forms and procedures for filing an Appeal available to facilities that provide Covered Services to Members.

2. CalOptima shall provide the complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Appeal, and shall triage Member calls and route Appeals to GARS via an electronic system.

B. Appeal Process

1. GARS shall:

a. Date stamp and document the substance of the Appeal in the GARS database, verifying demographics and network affiliation.

b. Determine the category of Appeal (coverage dispute, ~~medical necessity~~Medical Necessity, non-coverage appeal, and other) based on the Appeal, assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of an Appeal, indicating receipt of the Appeal and identifying a GARS staff member whom the Member may contact regarding the Appeal, and provide the Member with an estimated completion date of Resolution.

d. Send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member, excluding expedited Appeals.

i. The date of the oral Appeal establishes the filing date for the Appeal.

e. Process the Appeal whether or not a signed written Appeal confirmation is received from the Member.

~~d.~~f. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Appeal.

~~e.~~g. Review and immediately process all Appeals of an imminent and serious threat to the health of a Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited review as required in the CalOptima contract with Department of Health Care Services (DHCS).

~~f.~~h. Escalate the Appeal for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Appeal.

~~g.~~i. Send the Member or Provider, if applicable, a Notice of Appeal Resolution letter within thirty (30) calendar days after receipt of the Appeal.

~~h.~~j. Translate Notice of Appeal Resolution letters into Threshold Languages, and offer oral interpretation for a Notice of Appeal Resolution letter for all other languages.

i. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the Notice of Appeal Resolution letter in the electronic file and document any oral notification provided to the Member.

2. The Notice of Appeal Resolution letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

~~a. Summary of the Member's Appeal;~~

a. ~~The investigation made in the review process, including any~~The results of the resolution and the date it was completed;

b. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

c. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

~~b.~~d. Any referrals to the Quality Improvement (QI) Department for quality of care review;

~~c.~~e. Alternative resources or references, when applicable; and

~~d. The Member's right to a State Hearing.~~

~~3.~~f. ~~GARS staff shall close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the Notice of Appeal Resolution letter and document any oral notification provided to the Member end date and save the electronic file.~~The State Hearing process and right to request

and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

C. UM Pre-service Appeal

1. Request for UM Appeal

a. A CalOptima Member, or his or her Authorized Representative, or a Provider with Member's written consent, may request a UM Appeal within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network by the following methods:

i. To CalOptima's Customer Service Department, by telephone, or in person; or

ii. To CalOptima's Grievance and Appeals Resolution Services (GARS), by facsimile, in writing, or through the CalOptima Website at ~~www.caloptima.org~~www.caloptima.org.

~~b.~~ A Provider ~~or Practitioner~~ may request a UM Appeal on his or her own behalf within sixty (60) calendar days after receipt of ~~a NABD/NOA from CalOptima regarding Covered Services~~the denial for ~~a CalOptima Member, with the Member's written consent. The Provider~~authorization or ~~Practitioner shall:~~

b. ~~i. Submit~~payment for services already received by the ~~request orally or in writing, via mail or facsimile, to CalOptima's Grievance and Appeals Resolution Services.~~ Member.

c. This request serves as the documentation of the substance of the Appeal and any action taken;

~~ii~~i. Include all relevant material, such as clinical documentation or other documentation supporting the request; and

~~iii~~ii. Clearly label the request with "UM Appeal."

2. Acknowledgement of UM ~~Pre-service~~ Appeal

~~a. In instances of an oral Appeal request, excluding expedited Appeals, made by the Member, CalOptima shall send a written confirmation of the oral Appeal for Member's signature.~~

~~i. The date of the oral Appeal establishes the filing date for the Appeal.~~

~~ii. In the event that CalOptima does not receive a written, signed Appeal confirmation from the Member, CalOptima shall neither dismiss nor delay resolution of the Appeal.~~

~~b.~~a. Except as otherwise provided in Section III.D of this policy, CalOptima's Grievance and Appeals Resolution Services shall send the CalOptima Member, or Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, an Acknowledgment Letter that is dated and postmarked within five (5) calendar days after receipt of a UM Appeal.

~~c.~~b. The letter shall indicate the receipt of the UM Appeal, and identify a Grievance and Appeals Resolution Services staff member whom the Member, Authorized Representative

or Provider, acting on behalf of the Member with the Member's written consent, may contact if they choose to submit additional information (written or in person) and/or the request to review or obtain a copy of the records in connection with the UM Appeal.

3. UM Pre-service Appeal Processing

   a. Upon receipt of a UM Appeal from a CalOptima Member or his or her Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, an appeals nurse specialist in CalOptima's Grievance and Appeals Resolution Services shall investigate the Appeal, including any aspects of clinical care involved, by:

      i. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider ~~or Practitioner~~, or Member without regard to whether such information was submitted or considered in the initial action;

      ii. Obtaining and reviewing the Health Network's initial UM decision and supporting documentation, including relevant Medical Records; or

      iii. Preparing the case file for review by CalOptima's CMO or his or her Designee.

   b. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action and did not make the initial utilization management decision.

   c. CalOptima shall utilize specialist consultants, as appropriate.

4. UM Pre-service Appeals Resolution

   a. Except as otherwise provided in Section III.D of this policy, CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

      i. If CalOptima completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

      ii. If CalOptima does not completely overturn the denial, such written notice shall include information regarding the title, qualification, and specialty of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures, and the Member's right to have a representative act on their behalf when he or she Appeals.

      iii. If CalOptima upholds a UM decision involving the delay, denial, or modification of health care services, the Notice of Appeal Resolution shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

iv. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, or the Member Handbook reference for excluded services~~.~~ and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.

b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

D. UM Expedited Appeal

1. If CalOptima determines, for a request from a Member, or when the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, Authorized Representative, or a Provider, may request an expedited UM Appeal to CalOptima as follows:

   a. A CalOptima Member, Authorized Representative, or Provider on behalf of the CalOptima Member, with the Member's written consent, may request an expedited UM Appeal by contacting CalOptima's Customer Service Department by telephone or in-person, or contacting CalOptima's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

   b. CalOptima staff shall inform the Member of limited time to present evidence in person or writing to support the UM Appeal.

2. Upon receipt of a Member request for an expedited UM Appeal, CalOptima's CMO or his or her Designee shall review the request to determine if expedited review criteria is met and shall conduct a medical review as deemed necessary based on whether a delay:

   a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or

   b. In the opinion of a Provider with knowledge of the Member's Medical Condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. CalOptima shall grant expedited Appeal requests concerning admission, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

4. Expedited Appeals filed by a physician shall be processed as expedited without further review.

5. CalOptima shall utilize specialist consultants, as appropriate.

6. CalOptima shall make a decision on the expedited UM Appeal as quickly as the medical decision requires but no later than seventy-two (72) hours after CalOptima receives the expedited UM Appeal request.

7. CalOptima shall notify a Member, the Member's Authorized Representative, or Provider that made the request on behalf of the CalOptima Member within twenty-four (24) hours, by telephone, and written notice within two (2) calendar days of the verbal notice, if the Appeal does not meet expedited UM Appeal criteria.

8. CalOptima shall notify the Member, the Member's Authorized Representative, and all involved Providers of the expedited UM Appeal decision by facsimile or verbal communication within seventy-two (72) hours after receiving the expedited UM Appeal request. CalOptima shall provide a written notice within one (1) business day after a verbal notice.

~~E. Extension of Timeframes~~

~~1. CalOptima shall extend the resolution timeframes for either standard or expedited Appeals by up to fourteen (14) calendar days if any of the following two (2) conditions apply:~~

~~a. The Member requests the extension;~~

~~b. CalOptima demonstrates to the satisfaction of the DHCS upon request, that there is a need for additional information and how the delay is in the Member's best interest.~~

~~2. For any extension not requested by the Member, CalOptima is required to provide the Member with written notice of the reason for the delay.~~

~~a. CalOptima shall make reasonable efforts to provide the Member with oral notice of the extension.~~

~~b. CalOptima shall provide written notice of the extension within two (2) calendar days and notify the Member of the right to file a Grievance if the beneficiary disagrees with the extension.~~

~~c. CalOptima shall resolve the Appeal as expeditiously as the Member's health condition requires but not beyond the initial fourteen (14) calendar day extension.~~

~~d.1. In the event CalOptima fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.~~

~~F. UM Post-service Appeal~~

~~a) A CalOptima Member, Authorized Representative, or Provider may request a UM Appeal within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member. This request shall serve as the documentation of the substance of the Appeal, and any action taken, by submitting the request to:~~

~~a. CalOptima's Customer Service Department by telephone or in person; or~~

~~b. CalOptima's Grievance and Appeals Resolution Services by facsimile, in writing; or through the CalOptima Website at www.caloptima.org.~~

~~b) A Provider may request a UM Appeal on his own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member.~~

~~c) Acknowledgement of UM Post-service Appeal~~

~~a. GARS shall send the CalOptima Member, or Authorized Representative, an Acknowledgment Letter that is dated and postmarked within five (5) calendar days after receipt of a UM Appeal.~~

~~b. The letter shall indicate the receipt of the UM Appeal and identify a Grievance and Appeals Resolution Services staff member whom the Member, Authorized Representative, or Provider may contact if they choose to submit additional information (written comments, documents or other information relevant to the Appeal or come in person) and/or the request to review or obtain a copy of the records in connection with the UM Appeal.~~

~~c. In instances of an oral Appeal request made by the Member, CalOptima shall send a written confirmation of the oral Appeal for Member's signature.~~

~~i. The date of the oral Appeal establishes the filing date for the Appeal.~~

~~ii. In the event that CalOptima does not receive a written, signed Appeal confirmation from the Member, CalOptima shall neither dismiss nor delay resolution of the Appeal.~~

~~4.~~E. UM Post-service Appeal processing

~~a.~~1. CalOptima Grievance and Appeals Resolution Services staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the Member, provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative, or Provider.

~~b.~~2. A Grievance and Appeals Resolution Services Appeals nurse shall investigate, review and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or his or her Designee for review.

~~c.~~3. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action, is of the same or similar specialty, and did not make the initial utilization management decision.

~~d.~~4. CalOptima shall utilize specialist consultants as appropriate.

5. UM Post-service Appeals resolution

a. If CalOptima completely overturns the decision, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

c. If CalOptima does not completely overturn the decision, such written notice shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the right to continue to receive benefits pending a State Hearing, and the Member's right to request a standard or expedited State Hearing, in

accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures and the Member's right to have a representative act on their behalf when he or she Appeals.

d. CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

e. If CalOptima upholds a UM decision involving the denial of health care services, the Notice of Appeal Resolution shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member.

f. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall clearly specify the provisions of the contract that exclude that service and or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested..

F. ~~5.~~ External Appeals

~~a.~~1. CalOptima shall annually inform Members of the right to a State Hearing through the Medi-Cal Member Newsletter, including that the information is also available on the CalOptima Website at www.caloptima.org. CalOptima must also advise Members of their right to file an expedited State Hearing.

~~b.~~2. CalOptima shall include written or electronic notifications to Members in the resolution letter detailing the State Hearing rights, time limitations and processes, including the contact information for the California Department of Social Services.

3. In the event CalOptima fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.

4. A Member eligible with California Children's Services (CCS) and transitioned into the Whole-Child Model Program, the Member's family or designated caregiver may appeal a Contintuity of Care limitation ~~to the DHCS director or his or her designee after exhausting the Appeal Process~~ in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and this policy.

G. In addition to any rights set forth in this policy, a Member shall also have the right to:

1. Request that CalOptima provide an interpreter, or auxiliary aide, for assistance in the Appeal Process, or to provide translation of Appeal correspondence; and

2. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

3. CalOptima shall inform a Member of ~~this~~ these rights annually, and in every Notice of Appeal Resolution letter.

~~a. A Member may request a State Hearing within one hundred twenty (120) calendar days after the Notice of Appeal Resolution.~~

~~b. To request a State Hearing, a Member may:~~

~~i. Write to: Department of Social Services~~
~~State Hearings Division~~
~~P. O. Box 944243, M.S. 19-37~~
~~Sacramento, CA 95814; or~~

~~ii. Call: (800) 952-5253, or for TDD only, (800) 952-8349.~~

~~d. A Member may represent him or herself at the State Hearing, or may be represented by a friend, relative, attorney, or other representative.~~

~~e. A Member may request continuation of services by requesting a State Hearing within ten (10) calendar days after the Notice of Appeal Resolution Appeal. CalOptima shall grant the Member Aid Paid Pending until a State Hearing decision is reached.~~

H. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

   a. Maintenance of the Appeal Process;

   b. Review of the operations; and

   c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Appeal Process.

I. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where an Appeal may be submitted, and related procedures regarding the Appeal Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Appeal, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima shall submit a report of aggregated Appeal data, as required by DHCS.

4. CalOptima shall submit on a quarterly basis aggregate and detailed Appeals data to the Quality Assurance Committee.

5. CalOptima shall submit a report of Appeals related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Appeals or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or

Multipurpose Senior Services Program (MSSP) if the Appeal was reported to the County of Orange or MSSP site.

6. CalOptima shall establish and maintain a system of aging of Appeals that are pending and unresolved for thirty (30) calendar days or more.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Notice of Appeal Resolution (Uphold)
C. Notice of Appeal Resolution (Overturn)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network (CCN) Members, or Members Enrolled in a Shared-Risk Group
D. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
~~D.~~E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
~~E.~~F. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~F.~~G. CalOptima Policy HH.1102: CalOptima Member ~~Complaint~~ Grievance
~~G.~~H. CalOptima Policy HH.1108: State Hearing Process and Procedures
~~H.~~I. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
~~I.~~J. CalOptima Member Handbook
~~J.~~K. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
~~K.~~L. Title 22, California Code of Regulations, § 53858
~~L.~~M. Title 28, California Code of Regulations, § 1300.68 (except Subdivision 1300.68(c)(g) and (h))
~~M.~~N. Title 28, California Code of Regulations, § 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
~~N.~~O. Title 42, Code of Federal Regulations, §§ 438.10, 438.402(c)(2)(ii), 438.402(c)(3)(ii), 438.406(b)(3), 438.408(d)(2)(ii), 438.410, 438.420(a)(b)(c)

VI. REGULATORY AGENCY APPROVAL(S)

~~A. 06/21/17: Department of Health Care Services~~
~~B.~~A. 02/03/16: Department of Health Care Services
~~C.~~B. 06/22/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	10/1995	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/1998	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	05/1999	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
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Revised	01/01/2007	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
Revised	01/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	06/01/2009	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2011	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2012	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
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Revised	01/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	TBD	GG.1510	Appeal Process	Medi-Cal

IX. GLOSSARY

Term	Definitions
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.~~For purposed of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
California Children's Services	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An expression of dissatisfaction about any matter other than an adverse benefit determination.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury

Term	Definitions
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Utilization Management (UM) Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.

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Policy #:	GG.1510
Title:	**Appeal Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	10/01/95
Revised Date:	TBD

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves Utilization Management (UM) appeals, including Adverse Benefit Determinations involving the delay, modification or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.

II. POLICY

A. CalOptima shall establish and maintain an Appeal Process pursuant to applicable statutory, regulatory and contractual requirements.

B. A Member, or a Member's Authorized Representative, or Provider acting on behalf of the Member, and with the Member's written consent, has the right to file an Appeal in the timeframes set forth in this policy.

C. CalOptima's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

D. CalOptima shall assist a Member requiring assistance with filing an Appeal, including, but not limited to, a Member with limited English proficiency (LEP), disabilities, or cultural needs and in accordance with Section III.G.1 of this Policy.

E. CalOptima shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

F. CalOptima shall refer all Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process.

G. CalOptima and a Health Network shall inform a Member, during the Appeal Process, of their right to request a State Hearing after the internal Appeal Process has been exhausted or should have been exhausted, and of their right to Aid Paid Pending, in accordance with CalOptima Policies HH.1108: State Hearings Process and Procedures and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

H. Neither CalOptima, nor any of its Health Networks, Practitioners, or other Providers shall discriminate against a Member, a Member's Authorized Representative, or a Provider on the grounds that he or she filed an Appeal.

I. A Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) sent by CalOptima or a Health Network notifying a Provider or a Member of a CalOptima or Health Network UM decision to delay, deny, modify, or recommend an alternative option to a requested service, shall

inform a Member of their right to file an Appeal within sixty (60) calendar days of the date of the NABD/NOA.

J. The Member UM Appeal process set forth in this policy is a separate process from the Member Grievance Process in CalOptima Policy HH.1102: Member Grievance and Member State Hearing Process in CalOptima Policy HH.1108: State Hearing Process and Procedures. It is also separate from Provider processes in CalOptima Policy HH.1101: CalOptima Provider Complaint.

K. CalOptima shall give a Member, a Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and law in support of the Appeal. CalOptima and a Health Network shall inform the Member, the Member's Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the resolution timeframes, including for expedited Appeals.

L. CalOptima and its Health Networks shall provide culturally and linguistically appropriate notices of the Appeals process to Members, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

M. A Member may be represented by anyone they choose during the Appeal process, including a legal representative.

N. The Member has the right to request an Appeal in the event that CalOptima or a Health Network fails to issue a NABD/NOA within the required time frame, which shall be considered a denial and therefore constitutes an Adverse Benefit Determination.

O. CalOptima shall provide, upon request by the Member, his or her Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, before and during the Appeals process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals process. CalOptima shall provide records at no cost.

P. CalOptima shall ensure that the person reviewing the UM Appeal was not involved in the initial determination and he or she is not the subordinate of any person involved in the initial determination.

Q. CalOptima shall ensure that for UM Appeals, the person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity; and

2. Any Appeal involving clinical issues.

R. A Member shall receive the continuation of the benefit until one (1) of the following occurs:

1. Member withdraws the Appeal;

2. Ten (10) days pass after CalOptima mails the NABD/NOA;

3. Grievance and Appeals Resolution Services (GARS) issues an Appeal decision adverse to the Member; and

4. The time period or service limits of a previously authorized service has been met.

T. A Provider, with the Member's written consent, may request a UM Appeal on behalf of the Member, for services rendered to that CalOptima Member, by submitting a written request to CalOptima within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network, in accordance with the provisions of this policy.

U. Upon notice of a CalOptima decision to deny an authorization request, a Member, a Member's Authorized Representative, or a Provider, acting on behalf of the Member with the Member's written consent, may request an expedited UM Appeal when it is determined or the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

V. All medical Appeals are referred to the Chief Medical Officer (CMO), or to his or her Designee, who has the authority to require corrective action, and did not make the initial utilization management decision.

W. CalOptima and a Health Network shall provide the CalOptima Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract.

X. CalOptima shall provide language assistance to Members, by CalOptima staff or language line interpreter services, for Threshold Languages to register and resolve Appeals.

III. PROCEDURE

A. Assistance to Members

1. CalOptima and a Health Network shall make complaint forms and procedures for filing an Appeal available to facilities that provide Covered Services to Members.

2. CalOptima shall provide the complaint forms and procedures to a Member upon request.

3. CalOptima's Customer Service Department shall assist a Member with questions regarding the procedures for filing Appeal, and shall triage Member calls and route Appeals to GARS via an electronic system.

B. Appeal Process

1. GARS shall:

a. Date stamp and document the substance of the Appeal in the GARS database, verifying demographics and network affiliation.

b. Determine the category of Appeal (coverage dispute, Medical Necessity, non-coverage appeal, and other) based on the Appeal, assign type and subtype descriptors, the responsible staff, and documentation of issue(s).

c. Send a Member an Acknowledgment Letter within five (5) calendar days after receipt of an Appeal, indicating receipt of the Appeal and identifying a GARS staff member whom the

Member may contact regarding the Appeal, and provide the Member with an estimated completion date of Resolution.

d. Send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member, excluding expedited Appeals.

   i. The date of the oral Appeal establishes the filing date for the Appeal.

e. Process the Appeal whether or not a signed written Appeal confirmation is received from the Member.

f. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima department or Health Network responsible for the services or operations that are the subject of the Appeal.

g. Review and immediately process all Appeals of an imminent and serious threat to the health of a Member, including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis and issue the decision within seventy-two (72) hours of receipt. CalOptima shall provide oral notice of the Resolution of an expedited review as required in the CalOptima contract with Department of Health Care Services (DHCS).

h. Escalate the Appeal for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Policy HH.1109: Complaint Decision Matrix, and shall issue a decision with respect to the Appeal.

i. Send the Member or Provider, if applicable, a Notice of Appeal Resolution letter within thirty (30) calendar days after receipt of the Appeal.

j. Translate Notice of Appeal Resolution letters into Threshold Languages, and offer oral interpretation for a Notice of Appeal Resolution letter for all other languages.

i. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), include a copy of the Notice of Appeal Resolution letter in the electronic file and document any oral notification provided to the Member.

2. The Notice of Appeal Resolution letter shall describe the Appeal, and provide a clear and concise explanation of the reasons for the decision, including, but not limited to:

a. The results of the resolution and the date it was completed;

b. If the denial determination is based in whole or in part on medical necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination;

c. If the requested service is not a covered benefit, it shall include the provision in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service; identify the document and page or section containing the provision, or provide a copy of the provision;

d. Any referrals to the Quality Improvement (QI) Department for quality of care review;

e. Alternative resources or references, when applicable; and

f. The State Hearing process and right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made.

C. UM Pre-service Appeal

1. Request for UM Appeal

a. A CalOptima Member, or his or her Authorized Representative, or a Provider with Member's written consent, may request a UM Appeal within sixty (60) calendar days from the date of the NABD/NOA from CalOptima or a Health Network by the following methods:

i. To CalOptima's Customer Service Department, by telephone, or in person; or

ii. To CalOptima's Grievance and Appeals Resolution Services (GARS), by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

b. A Provider may request a UM Appeal on his or her own behalf within sixty (60) calendar days after receipt of the denial for authorization or payment for services already received by the Member.

c. This request serves as the documentation of the substance of the Appeal and any action taken;

i. Include all relevant material, such as clinical documentation or other documentation supporting the request; and

ii. Clearly label the request with "UM Appeal."

2. Acknowledgement of UM Appeal

a. Except as otherwise provided in Section III.D of this policy, CalOptima's Grievance and Appeals Resolution Services shall send the CalOptima Member, or Authorized Representative, or Provider, acting on behalf of the Member with the Member's written consent, an Acknowledgment Letter that is dated and postmarked within five (5) calendar days after receipt of a UM Appeal.

b. The letter shall indicate the receipt of the UM Appeal, and identify a Grievance and Appeals Resolution Services staff member whom the Member, Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, may contact if they choose to submit additional information (written or in person) and/or the request to review or obtain a copy of the records in connection with the UM Appeal.

3. UM Pre-service Appeal Processing

a. Upon receipt of a UM Appeal from a CalOptima Member or his or her Authorized Representative or Provider, acting on behalf of the Member with the Member's written consent, an appeals nurse specialist in CalOptima's Grievance and Appeals Resolution Services shall investigate the Appeal, including any aspects of clinical care involved, by:

i. Reviewing the initial UM decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records or other information supplied by a Provider, or Member without regard to whether such information was submitted or considered in the initial action;

ii. Obtaining and reviewing the Health Network's initial UM decision and supporting documentation, including relevant Medical Records; or

iii. Preparing the case file for review by CalOptima's CMO or his or her Designee.

b. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action and did not make the initial utilization management decision.

c. CalOptima shall utilize specialist consultants, as appropriate.

4. UM Pre-service Appeals Resolution

a. Except as otherwise provided in Section III.D of this policy, CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

i. If CalOptima completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

ii. If CalOptima does not completely overturn the denial, such written notice shall include information regarding the title, qualification, and specialty of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures, and the Member's right to have a representative act on their behalf when he or she Appeals.

iii. If CalOptima upholds a UM decision involving the delay, denial, or modification of health care services, the Notice of Appeal Resolution shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

iv. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.

b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

D. UM Expedited Appeal

1. If CalOptima determines, for a request from a Member, or when the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, Authorized Representative, or a Provider, may request an expedited UM Appeal to CalOptima as follows:

    a. A CalOptima Member, Authorized Representative, or Provider on behalf of the CalOptima Member, with the Member's written consent, may request an expedited UM Appeal by contacting CalOptima's Customer Service Department by telephone or in-person, or contacting CalOptima's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Website at www.caloptima.org.

    b. CalOptima staff shall inform the Member of limited time to present evidence in person or writing to support the UM Appeal.

2. Upon receipt of a Member request for an expedited UM Appeal, CalOptima's CMO or his or her Designee shall review the request to determine if expedited review criteria is met and shall conduct a medical review as deemed necessary based on whether a delay:

    a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or

    b. In the opinion of a Provider with knowledge of the Member's Medical Condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. CalOptima shall grant expedited Appeal requests concerning admission, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility.

4. Expedited Appeals filed by a physician shall be processed as expedited without further review.

5. CalOptima shall utilize specialist consultants, as appropriate.

6. CalOptima shall make a decision on the expedited UM Appeal as quickly as the medical decision requires but no later than seventy-two (72) hours after CalOptima receives the expedited UM Appeal request.

7. CalOptima shall notify a Member, the Member's Authorized Representative, or Provider that made the request on behalf of the CalOptima Member within twenty-four (24) hours, by telephone, and written notice within two (2) calendar days of the verbal notice, if the Appeal does not meet expedited UM Appeal criteria.

8. CalOptima shall notify the Member, the Member's Authorized Representative, and all involved Providers of the expedited UM Appeal decision by facsimile or verbal communication within seventy-two (72) hours after receiving the expedited UM Appeal request. CalOptima shall provide a written notice within one (1) business day after a verbal notice.

E. UM Post-service Appeal processing

1. CalOptima Grievance and Appeals Resolution Services staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the Member, provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative, or Provider.

2. A Grievance and Appeals Resolution Services Appeals nurse shall investigate, review and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or his or her Designee for review.

3. All medical Appeals are referred to the CMO, or to his or her Designee, who has the authority to require corrective action, is of the same or similar specialty, and did not make the initial utilization management decision.

4. CalOptima shall utilize specialist consultants as appropriate.

5. UM Post-service Appeals resolution

    a. If CalOptima completely overturns the decision, the letter shall state the decision and the date of the decision. CalOptima shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

    b. CalOptima and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and no later than seventy-two (72) hours from the date of the decision.

    c. If CalOptima does not completely overturn the decision, such written notice shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the right to continue to receive benefits pending a State Hearing, and the Member's right to request a standard or expedited State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures and the Member's right to have a representative act on their behalf when he or she Appeals.

    d. CalOptima shall send to the Member and Providers, as appropriate, a Notice of Appeal Resolution within thirty (30) calendar days after receipt of the UM Appeal.

    e. If CalOptima upholds a UM decision involving the denial of health care services, the Notice of Appeal Resolution shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member.

    f. If CalOptima upholds a UM Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the Notice of Appeal Resolution shall clearly specify the provisions of the contract that exclude that service and or the Member Handbook reference for excluded services and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested..

F. External Appeals

1. CalOptima shall annually inform Members of the right to a State Hearing through the Medi-Cal Member Newsletter, including that the information is also available on the CalOptima Website

at www.caloptima.org. CalOptima must also advise Members of their right to file an expedited State Hearing.

2. CalOptima shall include written or electronic notifications to Members in the resolution letter detailing the State Hearing rights, time limitations and processes, including the contact information for the California Department of Social Services.

3. In the event CalOptima fails to meet the resolution timeline, the Member is deemed to have exhausted CalOptima's internal Appeal process and may initiate a State Hearing.

4. A Member eligible with California Children's Services (CCS) and transitioned into the Whole-Child Model Program, the Member's family or designated caregiver may appeal a Contintuity of Care limitation in accordance with CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and this policy.

G. In addition to any rights set forth in this policy, a Member shall also have the right to:

1. Request that CalOptima provide an interpreter, or auxiliary aide, for assistance in the Appeal Process, or to provide translation of Appeal correspondence; and

2. Request a standard or expedited State Hearing with the Department of Social Services (DSS), in accordance with CalOptima Policy HH.1108: State Hearings Process and Procedures, and applicable laws.

3. CalOptima shall inform a Member of these rights annually, and in every Notice of Appeal Resolution letter.

H. Responsible staff

1. CalOptima's Chief Operating Officer (COO) shall have primary responsibility for:

a. Maintenance of the Appeal Process;

b. Review of the operations; and

c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima's administration of the program.

2. CalOptima's Director of GARS shall have primary responsibility for the oversight of the Appeal Process.

I. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where an Appeal may be submitted, and related procedures regarding the Appeal Process. CalOptima shall provide these notices in Threshold Languages, as required by CalOptima's contract with the Department of Health Care Services (DHCS).

2. CalOptima shall maintain written records of each Appeal, including the date of receipt, Member's name, description of the problem, names of the CalOptima staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, proposed resolution, and all Notice of Appeal Resolution

Letters, for a minimum of ten (10) years from the final date of the contract period for CalOptima's contract with DHCS or from the date of completion of any audit, whichever is later.

3. CalOptima shall submit a report of aggregated Appeal data, as required by DHCS.

4. CalOptima shall submit on a quarterly basis aggregate and detailed Appeals data to the Quality Assurance Committee.

5. CalOptima shall submit a report of Appeals related to a Member's receiving Long Term Care Services, as required by DHCS. CalOptima shall not be responsible for reporting Appeals or Resolutions related to a Member's receiving In-Home Supportive Services (IHSS) or Multipurpose Senior Services Program (MSSP) if the Appeal was reported to the County of Orange or MSSP site.

6. CalOptima shall establish and maintain a system of aging of Appeals that are pending and unresolved for thirty (30) calendar days or more.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Notice of Appeal Resolution (Uphold)
C. Notice of Appeal Resolution (Overturn)

V. REFERENCES

A. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network (CCN) Members, or Members Enrolled in a Shared-Risk Group
D. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. CalOptima Policy HH.1102: CalOptima Member Grievance
H. CalOptima Policy HH.1108: State Hearing Process and Procedures
I. CalOptima Policy HH.3012Δ: Non-Retaliation for Reporting Violations
J. CalOptima Member Handbook
K. Department of Health Care Services All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
L. Title 22, California Code of Regulations, § 53858
M. Title 28, California Code of Regulations, § 1300.68 (except Subdivision 1300.68(c)(g) and (h))
N. Title 28, California Code of Regulations, § 1300.68.01 (except Subdivision 1300.68.01(b) and (c))
O. Title 42, Code of Federal Regulations, §§ 438.10, 438.402(c)(2)(ii), 438.402(c)(3)(ii), 438.406(b)(3), 438.408(d)(2)(ii), 438.410, 438.420(a)(b)(c)

VI. REGULATORY AGENCY APPROVAL(S)

A. 02/03/16: Department of Health Care Services
B. 06/22/15: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/1995	GG.1510	Appeal Process for Utilization Management Decisions	Medi-Cal
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Revised	07/01/2013	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	09/01/2014	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	03/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	11/01/2015	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2016	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	01/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	07/01/2017	GG.1510	Appeal Process for Decisions Regarding Care and Services	Medi-Cal
Revised	TBD	GG.1510	Appeal Process	Medi-Cal

IX. GLOSSARY

Term	Definitions
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.
Adverse Benefit Determination	Denial, reduction, suspension, or termination of a requested service, including failure to provide a decision within the required timeframes.
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	For purposed of this policy, an individual appointed by a Member, or a Member's parent, guardian or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance.
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
California Children's Services	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	An expression of dissatisfaction about any matter other than an adverse benefit determination.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

Term	Definitions
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.
Utilization Management (UM) Appeal	A request by the Member, Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of a service.

1

<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

[CalOptima logo]

"Uphold"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

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

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf]* appealed the *[denial, delay, modification, or termination]* of *[Service requested]*.

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to uphold the decision. This request is still denied. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you need help reading this letter or have any questions, please call *[Grievance Resolution Services Staff Name]* at *[telephone number]*.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff

who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

[Medical Director name]

Enclosed: "Your Rights under Medi-Cal Managed Care"

(Enclose notice with each letter)

[CalOptima logo]

"Overturn"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

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

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You *[or Name of requesting provider or authorized representative on your behalf],* appealed the *[denial, delay, modification, or termination]* of *[Service requested].*

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on *[date]* and has decided to overturn the original decision. This request is now approved. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision].*

[CalOptima] has 72 hours to approve or provide you the service.

Your request has been approved *[under authorization number <#> from <date> to <date> with <provider> or payment has been made].* On *[Date]* at *[Time], <you were contacted and informed of the decision>; or <a message was left informing you of the decision>; or <a message was left asking for a call back>.*

If you need help reading this letter or have any questions, please call, *[Grievance and Appeals Resolution Services Staff Name],* at *[telephone number].*

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at 1-800-735-2929. You can also visit our website at www.caloptima.org.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at *[CalOptima Customer Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

Grievance and Appeals

Policy #:	GG.1814
Title:	**Appeals Process for Long Term Care Facility**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/1998
~~Last Review Date:~~	~~07/01/17~~
~~Last~~ Revised Date:	~~07/01/17~~TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

I. PURPOSE

This policy defines the process by which a Long Term Care (LTC) Facility provider may Appeal a CalOptima post-service Level of Care decision to deny, modify, or recommend alternative options to a request for LTC Facility daily rate services for a Medi-Cal, or OneCare Connect Member.

II. POLICY

A. Upon receipt of a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA) or Notice of Denial informing a LTC Facility provider of a denial, modification, or recommendation for an alternative option to a requested Long Term Care Facility daily rate, the LTC Facility provider shall have the right to appeal the Level of Care decision in accordance with the provisions set forth in this P~~p~~olicy.

B. In order to appeal the decision, a LTC Facility provider shall request reconsideration of the decision by submitting a written request for an Appeal within sixty (60) calendar days after receiving the NABD/NOA or Notice of Denial from CalOptima.

C. If CalOptima denies a LTC Facility provider's Appeal for the Level of Care, the LTC Facility provider may submit an Appeal for the Level of Care decision, within the applicable timeframe, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: CalOptima Provider Complaint.

III. PROCEDURE

A. A LTC Facility provider may request reconsideration of a Level of Care decision by submitting an Appeal, in writing, to the Grievance and Appeals Resolution Services (GARS) Department. The LTC Facility provider shall:

1. Submit the written request within sixty (60) calendar days after the date of the NABD/NOA or Notice of Denial;

2. Include all relevant materials, such as clinical documentation or other documentation supporting the request;

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3. Clearly label the request with "Appeal;" and

4. Include a new LTC Authorization Request Form (ARF).

B. Acknowledgement of LTC Appeal

1. The CalOptima Grievance and Appeal Resolution Services (GARS) Department shall send an Acknowledgment Letter within five (5) calendar days after receipt of a LTC Appeal.

2. The letter shall indicate the receipt of the LTC Appeal and identify a GARS nurse who can be contacted if they choose to submit additional information, including written comments, documents, or other information relevant to the Appeal.

C. CalOptima shall reconsider the Level of Care decision based upon a review of medical records and other documentation, as submitted by the LTC Facility provider, to support the Level of Care, including, but not limited to nursing notes, physician notes, and other records.

D. A GARS nurse shall investigate, review, and summarize the Appeal history and documentation, including any aspects of clinical care involved; for submission to the Chief Medical Officer (CMO) or their Designee for review.

E. For Medical Necessity decisions, CalOptima's CMO or their Designee shall render a decision.

F. Resolution of LTC Appeal

1. CalOptima shall send to the Provider, as appropriate, an Appeal Resolution Letter within thirty (30) calendar days after receipt of the LTC Appeal.

A. CalOptima shall notify the LTC Facility provider, in writing, of the decision. If CalOptima upholds the Level of Care decision to deny, modify, or recommend an alternative option to a requested LTC Facility daily rate, the LTC Facility provider notification shall include information regarding the LTC Facility provider's right to file a Complaint in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Appeal Resolution Letter

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy CMC.1000: Glossary of Terms
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. CalOptima Policy MA.9006: CalOptima Provider Complaint
G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. Title 22, California Code of Regulations (C.C.R.), §51003(g)
I. Title 22, California Code of Regulations (C.C.R.), §51334

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J. Title 22, California Code of Regulations (C.C.R.), §51335

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 02/03/16: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	01/01/1998	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	09/01/2004	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	02/01/2007	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	03/01/2008	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	11/01/2015	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
Revised	06/01/2016	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
Revised	07/01/2017	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect
Revised	TBD	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
Appeal	For the purposes of this policy, a request by a Provider for review of any decision to deny, modify, or recommend alternative options to a requested Level of Care decision.
Acknowledgement Letter	A written statement acknowledging receipt of a Complaint or Appeal.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility	Long Term Care (LTC) facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B [Skilled Nursing Facility (SNF)].
Level of Care	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee-beneficiary of a CalOptima program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

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Policy #:	GG.1814
Title:	**Appeals Process for Long Term Care Facility**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare Connect

I. PURPOSE

This policy defines the process by which a Long Term Care (LTC) Facility provider may Appeal a CalOptima post-service Level of Care decision to deny, modify, or recommend alternative options to a request for LTC Facility daily rate services for a Medi-Cal, or OneCare Connect Member.

II. POLICY

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B. In order to appeal the decision, a LTC Facility provider shall request reconsideration of the decision by submitting a written request for an Appeal within sixty (60) calendar days after receiving the NABD/NOA or Notice of Denial from CalOptima.

C. If CalOptima denies a LTC Facility provider's Appeal for the Level of Care, the LTC Facility provider may submit an Appeal for the Level of Care decision, within the applicable timeframe, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: CalOptima Provider Complaint.

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2. Include all relevant materials, such as clinical documentation or other documentation supporting the request;

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1. The CalOptima Grievance and Appeal Resolution Services (GARS) Department shall send an Acknowledgment Letter within five (5) calendar days after receipt of a LTC Appeal.

2. The letter shall indicate the receipt of the LTC Appeal and identify a GARS nurse who can be contacted if they choose to submit additional information, including written comments, documents, or other information relevant to the Appeal.

C. CalOptima shall reconsider the Level of Care decision based upon a review of medical records and other documentation, as submitted by the LTC Facility provider, to support the Level of Care, including, but not limited to nursing notes, physician notes, and other records.

D. A GARS nurse shall investigate, review, and summarize the Appeal history and documentation, including any aspects of clinical care involved; for submission to the Chief Medical Officer (CMO) or their Designee for review.

E. For Medical Necessity decisions, CalOptima's CMO or their Designee shall render a decision.

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A. CalOptima shall notify the LTC Facility provider, in writing, of the decision. If CalOptima upholds the Level of Care decision to deny, modify, or recommend an alternative option to a requested LTC Facility daily rate, the LTC Facility provider notification shall include information regarding the LTC Facility provider's right to file a Complaint in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

A. Acknowledgment Letter
B. Appeal Resolution Letter

V. REFERENCES

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J. Title 22, California Code of Regulations (C.C.R.), §51335

VI. REGULATORY AGENCY APPROVAL(S)

A. 06/21/17: Department of Health Care Services
B. 02/03/16: Department of Health Care Services

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1998	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	09/01/2004	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	02/01/2007	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	03/01/2008	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal
Revised	11/01/2015	GG.1814	Appeals Process for Long Term Care Facility Daily Rate Denial, Modification, or Recommendation	Medi-Cal OneCare Connect
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Revised	07/01/2017	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect
Revised	TBD	GG.1814	Appeals Process for Long Term Care Facility	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
Appeal	For the purposes of this policy, a request by a Provider for review of any decision to deny, modify, or recommend alternative options to a requested Level of Care decision.
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Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility	Long Term Care (LTC) facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B [Skilled Nursing Facility (SNF)].
Level of Care	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	An enrollee-beneficiary of a CalOptima program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

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<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>

Dear «Mr/Ms. Last Name»:

CalOptima received your [grievance or appeal] on <Date>. Thank you for letting us know about your concerns. Your input helps us assist you with your health care needs.

We are investigating your [grievance or appeal] and will call you if we have any questions. Please call us if you have changed your address or telephone number. We will send you a written response to your [grievance or appeal] within 30 calendar days from the date it was received.

If you have questions about this letter or would like to submit additional information about your [grievance or appeal], either in person or in writing, please call<SPECIALIST NAME>, Resolution Specialist, at <PHONE NUMBER>. You may also examine the papers related to your complaint before and during the complaint process by contacting <Name of Assigned Specialist>.

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**.

Sincerely,

Grievance and Appeals

<DATE>

<NAME>
<ADDRESS>
<CITY,STATE,ZIP>
Attention: <NAME>

RE: <MEMBER NAME>
ID #: <CIN>
DOS: <DATE OF SERVICE>

Dear <Provider>:

This letter is in response to the provider appeal CalOptima received on <DATE> for the above-referenced dates of service with respect to <_____> for CalOptima member, <_____>. The denial was issued due to <_____>.

In your appeal, you state that <_____>.

CalOptima's Grievance and Appeals Resolution Services has completed a review of the submitted appeal letter, <_____> and other supporting documentation available. As a result of this review, CalOptima has made the decision to <uphold or overturn> the denial based on the following:

- <_____>.

Based on the foregoing, <_____>.

If you disagree with this determination, you may file a complaint within sixty (60) calendar days after the date of this letter directed to:

CalOptima
Grievance and Appeals Resolution Services
505 City Parkway West
Orange, CA 92868

Should you have any questions regarding this letter, you may contact me at (714) <_____>.

Sincerely,

<Nurse Specialist Name>, RN

Grievance and Appeals Resolution Services

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 20, 2019
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item
10. Consider Recommending Board of Directors' Approval of Policy GG.1657, the Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting Policy

Contact
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality & Population Health Management, (714) 246-8400

Recommended Actions
Recommend Board of Directors approval of Policy GG.1657, Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting.

Background/Discussion
The Medical Board of California (Medical Board) and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy has been developed to comply with the Medical Board and the NPDB requirements for reporting adverse actions against a CalOptima Practitioner.

Fiscal Impact
There is no anticipated fiscal impact to the recommended action.

Concurrence
Gary Crockett, Chief Counsel

Attachments
GG.1657: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting

/s/ Michael Schrader — *2/14/2019*
Authorized Signature — **Date**

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Policy #:	GG.1657ΔPP
Title:	**Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader _____
Effective Date:	TBD
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

The Medical Board of California (Medical Board) and the National Practitioner Data Bank (NPDB) have imposed legal requirements for reporting certain actions related to the credentialing and peer review processes. This policy is to comply with the Medical Board and the NPDB requirements for reporting adverse actions against a CalOptima Practitioner.

II. POLICY

A. CalOptima and its delegated Health Networks shall comply with Medical Board and NPDB requirements for reporting certain actions related to CalOptima Practitioner credentialing and peer review activities.

B. If a reportable action is taken by CalOptima against a Practitioner, then CalOptima is the entity responsible for making the report(s) required by this Policy unless such reports are not required by applicable law.

C. Health Networks shall have policies and procedures that address credentialing and peer review reporting requirements. If a reportable action is taken by a Health Network against a Practitioner, then the Health Network is the entity responsible to make the report(s) unless such reports are not required by applicable law.

1. If a reportable action is taken by a Health Network, the Health Network shall report the reportable action, via mail or electronically, to the CalOptima Quality Improvement Department Director within thirty (30) calendar days from the date the action was reported.

III. PROCEDURE

A. Reports to the Medical Board Based on Business and Professions Code § 805

1. Entity Required to Report

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a. Only one peer review body is required to file an 805 Report for a Practitioner's Medical or Disciplinary Cause or Reason. If another peer review entity reports a Practitioner, CalOptima is not required to file a separate 805 Report attributable to the same conduct by the Practitioner.

2. Actions Requiring Reports

a. An 805 Report is filed with the Medical Board whenever any of the following actions become final:

i. Denial of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

ii. Non-renewal of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iii. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason;

iv. Termination of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason; or

v. Restriction on a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason;

vi. Imposition of summary suspension of a Practitioner's CalOptima participation or Health Network participation in CalOptima programs for a Medical or Disciplinary Cause or Reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

b. An 805 Report is filed with the Medical Board if the Practitioner takes any of the following actions listed below:

i. Resignation or leave of absence by a Practitioner from CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason;

ii. Withdrawal or abandonment of a Practitioner's application for CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or

Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason; or

iii. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima participation or Health Network participation in CalOptima programs after: (1) notice of an investigation initiated for a Medical or Disciplinary Cause or Reason; or (2) notice that his or her application is denied or will be denied for a Medical or Disciplinary Cause or Reason.

3. Timeframe for filing an 805 Report

a. Denial, Non-Renewal, Restriction or Termination

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the conclusion of all of the proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, if a denial, non-renewal, restriction or termination results from such proceedings;

ii. CalOptima shall file an 805 Report within fifteen (15) calendar days if the Practitioner's participation is restricted for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a Medical or Disciplinary Cause or Reason.

b. Summary Suspension

i. CalOptima shall file an 805 Report within fifteen (15) calendar days following the imposition of summary suspension, if the summary suspension remains in effect for a period in excess of fourteen (14) consecutive days.

a) CalOptima will also file an additional 805 Report with the Medical Board about the same Practitioner following conclusion of all proceedings under CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, or after the effective date of resignation or leave of absence by a Practitioner related to such summary suspension/investigation, within the timeframes provided in Section III.A.3.a.i. and Section III.A.3.c.i.

c. Resignation, Withdrawal or Leave of Absence

i. CalOptima shall file an 805 Report within fifteen (15) calendar days after the effective date of resignation or leave of absence by a Practitioner.

4. Exhaustion of Fair Hearing Rights

a. For any action taken by CalOptima pursuant to Section III.A.2.a.i. through Section III.A.2.a.iv., CalOptima shall not file an 805 Report until the Practitioner has had the opportunity to either waive or exhaust his/her Fair Hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

5. Notification to the Practitioner

a. CalOptima shall provide the Practitioner with a copy of the 805 Report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

6. Additional Reporting Requirements

a. If the Practitioner is an osteopathic physician, dentist or psychologist, CalOptima shall also file a copy of the 805 Report with the Practitioner's respective Board (e.g. Osteopathic Medical Board of California, Dental Board of California, California Board of Psychology.)

B. Reports to the Medical Board Based on Business and Professions Code § 805.01

1. Actions Requiring Reports

a. An 805.01 Report is filed with the Medical Board whenever a peer review body (e.g. the Credentialing and Peer Review Committee) makes a final decision or recommendation, as specified in Section III.A.2.a.i. through Section III.A.2.a.iv. above, resulting in a final proposed action to be taken against a Practitioner based on the peer review body's determination, following formal investigation of Practitioner, that any of the acts listed below, may have occurred:

i. Incompetence, gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a matter as to be dangerous or injurious to any person or the public;

ii. The use of, or prescribing for or administering to himself/herself, any controlled substance; or use of any dangerous drug, as defined in Business and Professions Code Section 4022, or of alcoholic beverages, that is dangerous or injurious to the Practitioner, any other person, public, or that the Practitioner's ability to practice safely is impaired by use;

iii. Repeated acts if clearly excessive prescribing, furnishing, or administering of controlled substances or related acts of prescribing, dispensing or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason therefore (note that in no event shall a Practitioner who is lawfully treating intractable pain be reported for excessive prescribing); or

iv. Sexual misconduct with one or more patients during a course of treatment or examination.

2. Timeframe for filing an 805.01 Report

a. CalOptima shall file an 805.01 Report within fifteen (15) calendar days after a final decision or recommendation regarding disciplinary action based upon a formal

investigation that concludes that based on an allegation that any of the acts listed in Section III.B.1. of this Policy have occurred.

3. Fair Hearing Rights

   a. CalOptima shall file an 805.01 Report (distinct from an 805 Report) regardless of whether the Practitioner is afforded his/her Fair Hearing Rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

   a. CalOptima shall provide the Practitioner with a copy of the 805.01 report and notice advising the Practitioner of his/her right to submit additional statements or other information, electronically or otherwise to the Medical Board and that information submitted electronically will be disclosed to those who request it, pursuant to Section 800(c) of the Business and Professions Code.

C. Reports to the National Practitioner Data Bank

1. Actions Requiring Reports

   a. An NPDB Report is filed whenever any of the following actions become final:

      i. An adverse Clinical Privileges action that is based on the Practitioner's professional competence or professional conduct which adversely affects or could adversely affect the health or welfare of a patient when that action adversely affects the Practitioner's authority to provide care to CalOptima patients for more than thirty (30) calendar days. This includes actions taken against a Practitioner's privileges including reducing, restricting, suspending, revoking, denying or not renewing privileges;

      ii. Acceptance of the Practitioner's surrender of Clinical Privileges, or any restriction of such privileges by a Practitioner:

         a) While the Practitioner is under investigation relating to possible incompetence or improper professional conduct; or

         b) In return for not conducting such an investigation or proceeding.

      iii. Withdrawal of an initial application by Practitioner for Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action;

      iv. Practitioner does not apply for renewal of Clinical Privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action; or

v. Summary suspension imposed for more than thirty (30) days based on the Practitioner's professional competence or professional conduct of the Practitioner that adversely effects, or could adversely affect the health and welfare of a patient and is the result of a professional review action.

2. Timeframe for filing an NPDB Report

a. CalOptima shall file an NPDB Report within thirty (30) calendar days from the date the adverse action was taken or authority to provide care to CalOptima patients is voluntarily surrendered.

3. Fair Hearing Rights

a. Except in the event of a summary suspension in effect less than thirty-one (31) consecutive days or a surrender or restriction of authority to provide care to CalOptima patients, CalOptima shall file a NPDB Report after the Practitioner has had the opportunity to either waive or exhaust his/her fair hearing rights in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

4. Notification to the Practitioner

a. The NPDB will mail a copy of the submitted report to the Practitioner named in the report. The Practitioner will have the opportunity to review the report for accuracy, and may add a statement to the report, or may dispute the report directly with the NPDB.

5. Additional Reports

a. CalOptima shall file a Revision-to-Action report to supplement an initial report to the NPDB if the summary suspension of a Practitioner is modified or revised as part of CalOptima's final decision in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners.

D. Persons at CalOptima Required to Report

1. Reports to the Medical Board Based on Business and Professions Code § 805

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.A.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805 Report with the Medical Board in the appropriate time required in Section III.A.3. of this Policy.

2. Reports to the Medical Board Based on Business and Professions Code § 805.01

a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.B.2. of this Policy, the Chief Medical Officer or Physician Designee who participates on CPRC, shall file an 805.01 Report with the Medical Board in the appropriate time required in Section III.B.3. of this Policy.

3. Reports to the National Practitioner Data Bank

   a. If CalOptima or the CalOptima Credentialing and Peer Review Committee take any action as described in Section III.C.2. of this Policy, Quality Improvement Credentialing Supervisor, shall file a report with the NPDB in the appropriate time required in Section III.C.3. of this Policy.

IV. ATTACHMENTS

A. Sample 805 Report
B. Sample 805.01 Report
C. Sample NPDB Report

V. REFERENCES

A. California Welfare and Institutions Code, § 14087.58(b)
B. California Business and Professions Code, §§ 805, 805.01 and 809
C. California Health and Safety Code § 1370
D. CalOptima Contract for Health Care Services
E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima PACE Program Agreement
H. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
I. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
J. Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §11101 *et seq.*
K. National Practitioner Data Bank regulations, 45 CFR Part 60
L. National Practitioner Data Bank 2015 Guidebook
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing (2018) CR:7, Element A, Factor 2

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. TBD

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GG.1657ΔPP	Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting	Med-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Clinical Privileges	As provided in the NPDB Guidebook, Clinical Privileges are privileges, and other circumstances (e.g. network participation and panel membership) in which a physician, dentist, or other health care Practitioner is permitted to furnish medical care by a health care entity.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Network	A Physician Hospital Consortium (PHC), physician medical group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in Business and Professions Code Section 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a State to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 (HCQIA) and its implementing regulations.

MEDICAL BOARD OF CALIFORNIA
Central Complaint Unit

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians, podiatrists, licensed midwifes and physician assistants must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason. Reports on osteopathic physicians, dentists and psychologists should be directed to their respective Boards. Please see the reverse/second page of this form for further information.

******PLEASE PRINT OR TYPE******

REPORTING ENTITY

Please check type of Reporting Entity	☐ Health Care Facility or Clinic – §805(a)(1)(A)	☐ Health Care Service Plan - §805(a)(1)(B)
	☐ Professional Society - §805(a)(1)(c)	☐ Medical Group or Employer - §805(a)(1)(D)
	☐ Ambulatory Surgical Center - §805(a)(1)(A)	

Name	Telephone #
Chief Executive Officer/Medical Director/Administrator	Chief of Medical Staff
Name of person preparing report	Telephone #
Street address City	State Zip code

LICENTIATE

Name	License #

☐ Physician ☐ Podiatrist ☐ Licensed Midwife ☐ Physician Assistant

ACTION TAKEN

Date(s) of Action(s) and Duration (attached additional sheets if necessary)

Type(s) of Action(s) - Check all that apply. **CHECK HERE IF THIS IS A SUPPLEMENTAL REPORT** ☐

(a) For a medical disciplinary cause or reason:
- ☐ Denial/rejection of application for staff privileges
- ☐ Denial/rejection of application for membership
- ☐ Termination or revocation of staff privileges
- ☐ Termination or revocation of membership
- ☐ Termination or revocation of employment

(b) For a cumulative total of 30 days or more for any 12 month period, and for a medical disciplinary cause or reason:
- ☐ Restriction(s) imposed on staff privileges
- ☐ Restriction(s) imposed on membership
- ☐ Restriction(s) imposed on employment
- ☐ Restriction(s) voluntarily accepted on staff privileges
- ☐ Restriction(s) voluntarily accepted on membership
- ☐ Restriction(s) voluntarily accepted on employment

If staff privileges were restricted, list specific restrictions imposed or voluntarily accepted:

(c) Following notice of an impending investigation based on information indicating medical disciplinary cause or reason:
- ☐ Licentiate resigned from staff
- ☐ Licentiate resigned from membership
- ☐ Licentiate resigned from employment
- ☐ Licentiate took leave of absence from staff
- ☐ Licentiate took leave of absence from membership
- ☐ Licentiate took leave of absence from employment

(d) For a summary suspension that remains in effect for a period in excess of 14 days for a medical disciplinary cause or reason:
- ☐ Imposition of summary suspension on staff privileges
- ☐ Imposition of summary suspension on employment
- ☐ Imposition of summary suspension on membership

DESCRIPTION OF ACTION: Attach additional sheet(s) describing the facts and circumstances of the medical disciplinary cause or reason and any other relevant information related to the action taken, including, but not limited to, the number of cases reviewed, time frame covered, any patient deaths involved, any malpractice filings as a result of the physician's actions, any expert/peer opinions obtained, etc.

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2528 FAX: (916) 263-2435 www.mbc.ca.gov

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ADDITIONAL INFORMATION

To complete this form, for definition of terms, when, how, and who should report, please refer to Section 805 of the California Business and Professions Code. You may access this information via www.leginfo.ca.gov under California Law, Business and Professions Code.

PLEASE NOTE: Section 805(k) of the California Business and Professions Code states: "A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, 'willful' means a voluntary and intentional violation of a known legal duty."

Section 805(l) of the California Business and Professions Code states: "Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that, under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code."

Section 805(m) of the California Business and Professions Code states: "A health care service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates."

CONFIDENTIALITY

This report is not a waiver of the confidentiality of medical records and committee reports. The contents of this report may be viewed only by those persons specified in Section 800(c) of the Business and Professions Code, except as required by Section 805.5 of the Business and Professions Code.

COPY TO LICENTIATE

A copy of the 805 report, with a cover letter informing the Licentiate of his or her right to submit additional statements or other information pursuant to Section 800(c) of the Business and Professions Code, must be sent by the reporting entity to the Licentiate.

SUPPLEMENTAL REPORT

A supplemental report must be made within thirty (30) days following the date the Licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as corrective action by the reporting entity.

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MEDICAL BOARD OF CALIFORNIA
Central Complaint Unit

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805.01 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians, physician assistants, licensed midwifes and podiatrists must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason.

REPORTING ENTITY

Please check type of Reporting Entity	☐ Health Care Facility or Clinic – §805(a)(1)(A)	☐ Health Care Service Plan - §805(a)(1)(B)
	☐ Professional Society - §805(a)(1)(c)	☐ Medical Group or Employer - §805(a)(1)(D)
	☐ Ambulatory Surgical Center - §805(a)(1)(A)	
Name		Telephone #
Chief Executive Officer/Medical Director/Administrator		Chief of Medical Staff
Name of person preparing report		Telephone #
Street address	City	State Zip code

LICENTIATE

Name			License #
☐ Physician	☐ Podiatrist	☐ Licensed Midwife	☐ Physician Assistant

REASON FOR FORMAL INVESTIGATION

Reason for formal investigation that resulted in recommended action:

- ☐ Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
- ☐ The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
- ☐ Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
- ☐ Sexual misconduct with one or more patients during a course of treatment or an examination.

RECOMMENDED ACTION

- ☐ Termination or revocation of staff privileges, membership or employment
- ☐ Summary suspension of staff privileges, membership or employment
- ☐ Restriction of staff privileges, membership or employment

List proposed specific restrictions:

Date final decision/recommendation made:

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2528 FAX: (916) 263-2435 www.mbc.ca.gov

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California Business and Professions Code Section 805.01

(a) As used in this section, the following terms have the following definitions:

(1) "Agency" has the same meaning as defined in Section 805.

(2) "Formal investigation" means an investigation performed by a peer review body based on an allegation that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) occurred.

(3) "Licentiate" has the same meaning as defined in Section 805.

(4) "Peer review body" has the same meaning as defined in Section 805.

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs (1) to (4), inclusive, may have occurred, regardless of whether a hearing is held pursuant to Section 809.2. The licentiate shall receive a notice of the proposed action as set forth in Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

(1) Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.

(2) The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(c) The relevant agency shall be entitled to inspect and copy the following documents in the record of any formal investigation required to be reported pursuant to subdivision (b):

(1) Any statement of charges.

(2) Any document, medical chart, or exhibit.

(3) Any opinions, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(d) The report provided pursuant to subdivision (b) and the information disclosed pursuant to subdivision (c) shall be kept confidential and shall not be subject to discovery, except that the information may be reviewed as provided in subdivision (c) of Section 800 and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) The report required under this section shall be in addition to any report required under Section 805.

(f) A peer review body shall not be required to make a report pursuant to this section if that body does not make a final decision or recommendation regarding the disciplinary action to be taken against a licentiate based on the body's determination that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) may have occurred.

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U.S. Department of Health & Human Services

NPDB National Practitioner Data Bank

Draft Medical Malpractice Payment Report (MMPR)
(Do not mail this form to the NPDB)

This form is for your convenience in drafting Medical Malpractice Payment Reports for ultimate submission to the NPDB. **Do not mail this form to the NPDB.** Medical Malpractice Payment Reports must be submitted to the National Practitioner Data Bank (NPDB) using the Integrated Querying and Reporting Service (IQRS), the Querying and Reporting XML Service (QRXS), or the Interface Control Document (ICD) Transfer Program (ITP), which are available at *https://www.npdb.hrsa.gov*.

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission. If spaces are provided for multiple responses to an item, you only need to complete as many of the responses as you have information for. There is no need to repeat responses or enter "Not Applicable," etc.

OMB # 0915-0126 expiration date 03/31/2021

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0126. Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857.

Personal Information

Subject Name

Last Name	First Name	Middle Name	Suffix
(25 characters)	*(15 characters)*	*(15 characters)*	*(4 characters)*

Is Subject Deceased?

- ☐ No
- ☐ Unknown
- ☐ Yes – Deceased Date (MMDDYYYY):

Gender: ☐ Male ☐ Female ☐ Unknown

Birth Date (MMDDYYYY)**:**

Home Address/Address of Record

(See List A-1 and A-2 for information on filling out non-U.S. and military addresses)

Street Address *(40 characters)*:
Address Line 2 *(40 characters)*:
City *(28 characters)*:
State (Choose State code from List A-1):
ZIP Code: -
Country (If U.S., leave blank; *20 characters*):

Work Information

Organization Name *(60 characters)*:
Address
(See Lists A-1 and A-2 for information on filling out non-U.S. and military addresses)

Street Address *(40 characters)*:
Address Line 2 *(40 characters)*:
City *(28 characters)*:
State (Choose State code from List A-1):
ZIP Code: -
Country (If U.S., leave blank; *20 characters*):

Social Security Numbers (SSN) (Format NNNNNNNNN)

1. **2.**
3. **4.**

Drug Enforcement Administration (DEA) Numbers *(9 characters)*

1. **2.**
3. **4.**

Professional Schools Attended (Name, City, State/Country; *200 characters*) **Year of Graduation** (Format YYYY)

1.
2.
3.
4.
5.

Occupation and State Licensure Information

(Provide at least one license. Check 'No License' if the subject does not have a State License Number. Up to 60 licenses may be provided.)

1. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

2. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

3. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

4. **State License Number** *(16 characters)*: **OR** ☐ No License
   State of Licensure (Choose State code from List A-1):
   Occupation/Field of Licensure (Choose one three-digit code from List B):
   Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

5. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

6. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

7. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

8. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

9. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

10. **State License Number** *(16 characters)*: **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

Hospital Affiliation(s)

	Name *(60 characters)*	**City** *(28 characters)*	**State** (Choose State code from List A-1)
1.			
2.			
3.			
4.			
5.			

Payments by This Payer for This Practitioner

If you made a single payment for multiple practitioners and if the settlement agreement or judgment does not specify an amount for each practitioner, you must allocate the total payment between the practitioners and specify an amount greater than zero for this practitioner. If a settlement agreement specifically states that no payment was made for this practitioner, do not file this report. The total amount paid or to be paid by you for all practitioners must be specified in the appropriate field. You must file a separate report for each practitioner named in the claim and judgment or settlement unless the judgment or settlement specifically states that no payment was made for that practitioner.

Amount of This Payment for This Practitioner

(Format NNNNNNNNN.NN): $

Date of This Payment (MMDDYYYY):

Select the payment type (i.e., Single or Multiple) to indicate whether the payment specified in the Amount of This Payment field is a single final payment or is one of multiple payments to be paid in series. Only the first payment of a series of payments must be reported, except when a preliminary payment is made before a final settlement is reached.

If this payment represents a preliminary payment prior to settlement:

1. Select One of Multiple Payments in this field; enter the preliminary payment amount in both the Amount of This Payment for This Practitioner and the Total Amount Paid or to be Paid by This Payer for This Practitioner fields; and
2. Explain the circumstances of the preliminary payment in the Description of the Judgment or Settlement field.
3. Once the settlement is reached, file a Correction Report and provide the revised total amount of all payments in the Total Amount Paid or to be Paid by This Payer for This Practitioner field.

If this payment represents a payment made after a final settlement, only the first payment of a series of payments must be reported. In these cases:

1. Report the amount of the first payment in the Amount of This Payment for This Practitioner field.
2. Complete the Total Amount Paid or to be Paid by This Payer for This Practitioner field, consistent with the instructions below.

This Payment Represents: ☐ A Single Final Payment ☐ One of Multiple Payments

If this report concerns a preliminary payment before a final settlement is reached and the total amount ultimately to be paid is unknown:

1. Enter only the amount of this payment; and
2. Explain in the Description of the Judgment or Settlement field;
3. Then, file a Correction Report once the settlement is reached and the total amount is known.

If this payment represents a payment made after a final settlement, only the first payment of a series of payments must be reported. If this payment is part of a structured settlement, report the cost of purchasing the structured settlement arrangement or the present value of the total payments to be made over the lifetime of the obligation if a structured settlement arrangement is not purchased.

Total Amount Paid or to Be Paid by This Payer for This Practitioner
(Format NNNNNNNNN.NN): $

Payment Result of: ☐ Judgment ☐ Settlement ☐ Payment Prior to Settlement

Date of Judgment or Settlement, if Any (MMDDYYYY):

Adjudicative Body Case Number (if Applicable; *20 characters*):

Adjudicative Body Name (if Applicable; *60 characters*):

Court File Number (if Applicable; *10 characters*):

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment
(Limit 4,000 characters including spaces and punctuation)

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Payments by This Payer for Other Practitioners in This Case	
Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case (Including the Amount Specified Above for This Practitioner; Format NNNNNNNNN.NN):	$
Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:	

Payment Information

Relationship of Entity to This Practitioner (Choose one from list):

Note: A health insurance company, managed care organization, or health care entity (such as a hospital, health plan, group practice, government agency and department that provides health care services) that makes a payment for a practitioner on its own staff because the company pays its own malpractice claims rather than having coverage for malpractice claims under an insurance policy issued by another company should report as a Self-Insured Organization. A State fund should select the code "State Medical Malpractice Payment Fund as the Primary Payer for the Practitioner" if the fund is the payer of first resort for a claim and select the code "State Medical Malpractice Payment Fund as a Secondary Payer for the Practitioner" if the fund is the payer for any amount in excess of the primary amount.

☐ Insurance Company – Primary Insurer
☐ Insurance Company – Excess Insurer
☐ Self-Insured Organization
☐ Insurance Guaranty Fund
☐ State Medical Malpractice Payment Fund as the Primary Payer for This Practitioner
☐ State Medical Malpractice Payment Fund as a Secondary Payer for This Practitioner

Payments by Others for This Practitioner

Complete if your entity is an Insurance Company or a Self-Insured Organization.

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?
☐ Yes
☐ No
☐ Unknown

Amount Paid or Expected to Be Paid by the State Fund (Format NNNNNNNNN.NN): $

Complete if your entity is an Insurance Company, an Insurance Guaranty Fund or a State Medical Malpractice Payment Fund.

Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?
☐ Yes
☐ No
☐ Unknown

Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies (Format NNNNNNNNN.NN): $

Classification of Act(s) or Omission(s)

Patient Information

Patient's Age at Time of Initial Event (enter 0 days if the patient is a fetus):
- ☐ Days (if less than 1 month)
- ☐ Months (if less than 1 year)
- ☐ Years
- ☐ Unknown

Patient's Gender: ☐ Male ☐ Female ☐ Unknown

Patient Type: ☐ Inpatient ☐ Outpatient ☐ Both ☐ Unknown

Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation)

Enter a narrative description of the actual diagnosis with which the patient presented for treatment. Do not report a misdiagnosis. If the patient had more than one condition, enter the condition most applicable to the alleged acts or omissions. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Description of the Procedure Performed

Enter a narrative description of the treatment rendered by the insured to the patient for the initial medical condition specified in this report. If more than one procedure was performed by the insured, report the one that is most significant to the claims generation. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Nature of Allegation (choose one from list)**:**

- ☐ Anesthesia Related
- ☐ Behavioral Health Related
- ☐ Diagnosis Related
- ☐ Equipment/Product Related
- ☐ IV & Blood Products Related
- ☐ Medication Related
- ☐ Monitoring Related
- ☐ Obstetrics Related
- ☐ Surgery Related
- ☐ Treatment Related
- ☐ Other Miscellaneous

Specific Allegation (Select the most significant allegation first.)

Note: Only select the same code for both allegations if the alleged act or omission occurred more than once and on different dates.

1. **Specific Allegation** (Choose one three-digit code from List C):

   Description (Only complete for Specific Allegation Code 999; *60 characters*)*:*

   Date of Event Associated With Allegation or Incident (MMDDYYYY):

2. **Specific Allegation** (Choose one three-digit code from List C):

   Description (Only complete for Specific Allegation Code 999; *60 characters*)*:*

   Date of Event Associated With Allegation or Incident (MMDDYYYY):

Outcome (Choose one from list)**:**

- ☐ Emotional injury only
- ☐ Insignificant injury
- ☐ Minor temporary injury
- ☐ Major temporary injury
- ☐ Minor permanent injury
- ☐ Major permanent injury
- ☐ Significant permanent injury
- ☐ Quadriplegic, brain damage, lifelong care
- ☐ Death
- ☐ Cannot be determined from available records

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based

Reporting entities must use this field to summarize the allegations of the plaintiff or claimant in demanding payment even if the reporting entity believes these allegations to be without merit. Reporters may also use this section to summarize important issues in the case and to provide, as needed, additional information not reported in the Classification of Acts or Omissions section of this report. *(Limit 4,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Entity Internal Report Reference

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the NPDB, but it will be provided on copies of the report sent to queriers.

Entity Internal Report Reference (e.g., claim number; *20 characters*):

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use (*20 characters*):

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Depression Screening Initiative Update

On December 1, 2016, CalOptima Board of Directors approved a $1,000,000 physician incentive program funded by Intergovernmental Transfer (IGT) 1 to increase the rate of depression screenings conducted during annual wellness visits for members ages 12 to 18. On February 20, 2018, the Quality Assurance Committee (QAC) approved a motion to recommend the Board of Directors ratify a $20 increase per depression screening to $50 for all screens completed by physicians for eligible members retroactively to May1, 2017, and authorize incentive payments of $50 per depression screening for members prospectively through May 2019, or until available funding has been exhausted, whichever comes first. On March 1, 2018, the Board of Directors approved the motion as recommended by the Committee.

The Committee asked staff to continue to monitor the volume of screenings and provide regular updates. Below is a summary of activities since the last update on September 12, 2018:

- On November 2, 2018, CalOptima presented at a provider Lunch and Learn meeting to educate and remind providers about the initiative.
- As of December 31, 2018, 6,994 members received a depression screening through the incentive program totaling $349,700 in paid claims to participating providers.
- In January 2019, CalOptima wrote and published an article about the incentive in the Orange County Medical Association e-newsletter, OCMA Connect, which was distributed to over 3,000 physicians.

This physician incentive program is scheduled to end in May 2019. As part of the project plan, staff will complete a final evaluation, including a provider survey, to assess the effectiveness of the program. Staff will use the knowledge and experience gained from this program to develop a new quality initiative to support depression screening and follow-up for expanded populations, i.e. adolescents and adults.

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Intergovernmental Transfer (IGT) Funding Update

Board of Directors' Quality Assurance Committee Meeting

February 20, 2019

Cheryl Meronk

Director, Strategic Development

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Agenda

- Background: CalOptima Share of IGT Funding
- Impact of Final Rule
- Fiscal Impact of IGT 8
- Potential Strategic Areas for IGT 8
- Key Considerations
- Next Steps

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Background: CalOptima Share of IGT Funding

IGT Number	Funding Year	CalOptima Share	Key Points
1	2010-11	$12.8M	• IGT 1-7 implemented prior to federal Medicaid and CHIP Final Rule
2	2011-12	$8.7M	
3	2012-13	$4.9M	
4	2013-14	$7.0M	
5	2014-15	$14.4M	
6	2015-16	$15.2M	
7	2016-17	$15.9M	
8 (est.)	2017-18	$43.2M	• Effective July 2017, the Final Rule prohibits retrospective payments to Medicaid managed care plans • DHCS implemented a new payment model for IGT funding

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Fiscal Impact of IGT 8

Description	FY 2017-18
Consolidated Revenue without IGT	$3.45B
IGT Revenue (Funding Partners & CalOptima)	$0.13B
Total Revenue including IGT	$3.58B
CalOptima Share of IGT Funding	$0.04B
% CalOptima IGT/ Total Revenue	*1.2%*

- IGT 8 is drastically different from previous IGTs as it will include:
  - ACA funding formula for the Medicaid Expansion population (i.e., 95/5 federal/state split)
  - ACA enhanced federal funding for the CHIP population (88/12 federal/state split)

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Impact of Final Rule

	IGT 1 – 7	IGT 8
Purpose	To enhance the health of Medi-Cal members we serve	To enhance Medi-Cal covered services
Rate	Retrospective calculation of Medi-Cal costs for prior rate years	Prospective payment model; included in our capitation rates from DHCS for the current year
Permitted Use	Fund enhanced services not already paid for or provided under our DHCS contract	Must be tied to Medi-Cal covered services provided under our DHCS contract
Operations	Reflected below the line and considered a pass through payment; no impact on the regular income statement	Part of our operating income and expenses and can plan during our normal budget process

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Potential Strategic Areas for IGT 8

- Starting with IGT 8
  - Must be used for Medi-Cal covered services included in CalOptima's DHCS contract
    - We already pay for contracted Medi-Cal services
    - Funding is not eligible for services that are NOT included in CalOptima's DHCS contract; has to be used for contracted services
  - Funding can be used to pay for contracted Medi-Cal services through:
    - Multi-year strategic provider rate changes
    - Increased funding of incentive programs/payouts
  - Advantage of increasing funding to existing incentive programs: Drive outcomes that improve quality of care for members
    - Increase member satisfaction
    - Direct provider behavior and improve outcomes

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Potential Strategic Areas for IGT 8 (cont.)

Strategic Area	Initiatives
Increase member access to health services/providers	• Offer incentives to increase member access to: ➢ Key specialties, including skilled nursing facilities and long term care ➢ Targeted services, including after-hours office visits • Reduce readmissions through post-hospitalization follow-up ➢ Post-transition primary care provider access incentives ➢ Nurse practitioner home visit ➢ Support member benefits education efforts for Medi-Cal ➢ Collaborate with community-based organizations to conduct concentrated outreach/education efforts ➢ Target activities to ethnic communities/threshold languages and include after-hour efforts
Increase Population Health Management	• Member health education and preventive services ➢ Implement texting outreach system • Trauma-informed care ➢ Required education and training • Pre-diabetes program ➢ Implement additional new requirements

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Potential Strategic Areas for IGT 8 (cont.)

Strategic Area	Initiatives
Increase services related to Member Health Enhancement Programs	• Field-based clinical team to provide care for members who are homeless • Field-based special population personal care coordinators (PCC) at high-volume clinics/FQHCs • Maternal Mental Health Program during pregnancy and postpartum ➢ Make enhancements to Bright Steps program • Pain management program ➢ Enhanced services to link to prior IGT initiative to address the opioid crisis • Extend 24/7 nurse triage service to Medi-Cal members
Provider Rates	• Should be strategic; incentives will drive outcomes vs. straight rate increases*

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Potential Strategic Areas for IGT 8 (cont.)

- Pay for Value (P4V) Program
  - Background
    - Recognizes and rewards health networks and CCN providers for demonstrating quality performance
    - Provides comparative information for members, providers and the public on CalOptima's performance against industry benchmarks
    - When combined with public reporting on quality, provides accountability for the additional funding providers receive based on quality performance
  - Recommendations
    - Consider using IGT funds to increase PMPM for Medi-Cal P4V program
    - Consider using IGT funds for additional member incentive dollars to promote participation in Population Health Programs

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Medi-Cal P4V Program Measures

2018-19 Measurement Year Measures	
Adult Clinical Measures	**Child Clinical Measures**
Adult Access to Preventive Care Services	Adolescent Well-Care Visits
Avoidance of Antibiotic Treatment in Adults with Bronchitis	Appropriate Testing for Children with Pharyngitis
Breast Cancer Screening	Appropriate Treatment for Children with URI
Cervical Cancer Screening	Childhood Immunizations: Combo 10
Diabetes Care: A1C Testing	Children's' Access to Primary Care Physicians: 12-19 yrs
Diabetes Care: Retinal Eye Exams	Medication Management for People with Asthma: 5-11 years 75% covered
Medication Management for People with Asthma: 19-50 years 75% covered	Well-Child Visits 3-6 years
	Well Child Visits in the First 15 months of Life: six well child visits
Adult and Child Member Experience Measures	
Getting Care Quickly	How Well Doctors Communicate
Getting Needed Care	Rating of PCP

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Key Considerations

- IGT 8
  - Funding must be:
    - Used for Medi-Cal members
    - Tied to Medi-Cal covered services included in CalOptima's DHCS contract
  - DHCS is not allowed to direct CalOptima's expenditure of the IGT payments
  - CalOptima will record IGT revenues and expenses as part of our Income and Expense
    - IGT funds were considered a pass through in prior years
  - IGT is authorized only one year at a time
    - Subject to change or potential elimination by DHCS/CMS
  - IGT expenditures need to be for a limited time and amount
  - Strategic funding in order to maximize impact to CalOptima's members
    - Increase member satisfaction and access to care

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Next Steps

- Develop recommendations
- Solicit stakeholder feedback
- Incorporate stakeholder feedback and develop final draft plan – April
- IGT 8 funds expected to be received May
- Final recommendations to Board – June 2019

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Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Telehealth Strategy - Executive Summary

- DHCS considers telehealth a cost-effective alternative to health care provided in-person. Medicaid regulations authorize telehealth using "interactive communications" and asynchronous store and forward technologies. Medi-Cal complies with state and federal regulations for telehealth and DHCS will post final revisions of the Medi-Cal Provider Manual section for telehealth, All Plan Letter, and other Provider Manual sections for telehealth in the spring of 2019.

- Developing and deploying a comprehensive telehealth strategy in collaboration with our health network and provider partners is one of the success factors to ensure CalOptima members are able to access quality care that is convenient for them, maintain CalOptima's number one Medi-Cal Managed Care Health Plan NCQA ranking, and meet the new NCQA Population Health Standards.

- Virtual Care Goals:
  - Improve member choice and experience
  - Improve member access to care
  - Improve provider efficiency and communication
  - Improve quality of referrals to specialists
  - Improve transitions of care

- Guiding Principles:
  - Flexibility to allow networks and providers to choose the platforms and vendors that are best for them
  - Integrate data across platforms and vendors
  - Meet regulatory compliance, security, privacy, and safety requirements
  - Use straightforward value-based reimbursement
  - Effective delegation oversite and regulatory compliance

- Proposed Next Steps:
  - Telehealth strategy discussion with Health Networks at the Health Network Forum on February 21, 2019
  - Conduct a comprehensive Health Network Telehealth Survey after February 25, 2019
  - Review DHCS final telehealth revisions in March 2019
  - Define a Telehealth Roadmap based on survey feedback and DHCS revisions in March 2019
  - Obtain CalOptima Board approval for Telehealth Program
  - Submit CalOptima 2019/2020 budget proposal

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Telehealth Strategy

Board of Directors' Quality Assurance Committee Meeting

February 20, 2019

David Ramirez, MD, Chief Medical Officer

Betsy Ha, RN, MS, LSSMBB, Executive Director, Quality & Population Health Management

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Background

- DHCS considers telehealth a cost-effective alternative to health care provided in-person
- Telehealth is not a distinct service, but a way that providers deliver health care to their patients that approximates in-person care
- Medicaid regulations authorize telehealth using “interactive communications” and asynchronous store and forward technologies

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Background

- DHCS's coverage and reimbursement policies for telehealth align with the California Telehealth Advancement Act of 2011 and federal regulations
- Medi-Cal complies with federal regulations for telehealth, which are the same for Medicaid as they are for Medicare
- DHCS sent a draft update of the Medi-Cal Provider Manual section for telehealth, draft All Plan Letter, and other Provider Manual sections for telehealth in October 2018 and held a webinar in December 2018
- DHCS will post the final revisions for telehealth in the spring of 2019

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Introduction

- Developing and deploying a comprehensive CalOptima telehealth strategy in collaboration with our health network and provider partners is one of the key success factors to ensure:
  - CalOptima members are able to access quality care that is convenient for them
  - Maintain CalOptima's number one Med-Cal Managed Care Health Plan NCQA ranking
  - Meet the new NCQA Population Health Standards

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Goals

- Improve member choice and experience
- Improve member access to care
- Improve provider efficiency and communication
- Improve quality of referrals to specialists
- Improve transitions of care

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Guiding Principles

- Flexibility to allow networks and providers to choose the platforms and vendors that are best for them
- Integrate data across platforms and vendors
- Meet regulatory compliance, security, privacy, and safety requirements
- Use straightforward value-based reimbursement
- Effective delegation oversite and regulatory compliance

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Current Medi-Cal Managed Care Plan Telehealth Use

Health Plan	Telehealth and Vendor
LA Care	• eConsult (SafetyNetConnect) • Evaluating Teladoc for video visits
Inland Empire Health Plan (IEHP)	• eConsult (SafetyNetConnect) • Doc to Doc virtual consultations • Baby-N-Me app • Nurse Advise Line
Health Plan of San Joaquin	• Telederm for over 6 years • Implementing PCP to Specialist e-consults (RubiconMD) • Exploring member to PCP telehealth • Nurse Advise Line
San Francisco Health Plan	• Member video visits (Teladoc)
Central California Alliance for Health	• eConsults (RubiconMD and Arista) • Member dermatology visits (Direct Derm)

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CalOptima Current State

- Member Portal implementation in progress
  - Member focus group on February 19, 2019
  - Awaiting DHCS approval
- Telepsychiatry Video Visits
  - Visit between member (in office) and psychiatrist (in different office)
  - PACE – Senior population
  - Radiant Health Center – LGBT population
- Behavioral Counseling Interventions for Alcohol Misuse
  - Policy authorizes sessions by telehealth modalities

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CalOptima Future State

- Asynchronous store and forward technologies (eConsults)
  - Leverage existing network efforts
  - Use CalOptima providers +/- vendor network providers
  - CalOptima incentives for providers to use eConsults
  - Data integration between provider, network, and CalOptima
- Interactive Communications (Video Visits)
  - Leverage existing network efforts
  - Use CalOptima providers +/- vendor network providers
  - CalOptima incentives for members to use video visits
  - Integration with CalOptima member portal

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Next Steps

- Telehealth strategy discussion with Health Networks at the Health Network Forum on February 21, 2019
- Conduct a comprehensive Health Network Telehealth Survey after February 25, 2019
- Review DHCS final telehealth revisions in March 2019
- Define a Telehealth Program Roadmap based on survey feedback and DHCS revisions in March 2019
- Obtain CalOptima Board approval for Telehealth Program
- Submit CalOptima 2019/2020 budget proposal

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Board of Director's Quality Assurance Committee Meeting
February 20, 2019

Quality Improvement Committee (QIC) Quarter 4 Update

QIC Meeting Dates: October 09, 2018; November 13, 2018; and December 11, 2018

- Summary
  - The following report to the QIC quarterly through various committees and subcommittees:
    - Case Management and Complex Case Management
    - Behavioral Health Integration (BHI)
    - Customer Service
    - Grievance & Appeals Resolution Services
    - Health Education & Disease Management (HE & DM)
    - Long-Term Services and Supports (LTSS)
    - Program of All-Inclusive Care for the Elderly (PACE)
    - Pharmacy & Therapeutics
    - Benefit Management
    - Utilization Management (UM)
    - Credentialing and Peer Review Committee (CPRC)
  - Accepted minutes from the following committees and subcommittees:
    - Utilization Management Committee (UMC): August 23, 2018
    - Behavioral Health QI Committee (BHQIC): August 28, 2018
    - Long-Term Services and Supports QI Subcommittee (LTSS-QISC): September 17, 2018
    - Grievance & Appeals Resolutions Services Committee (GARS): August 30, 2018
    - Member Experience Subcommittee (MEMX): September 18, 2018; October 02, 2018; October 16, 2018; and November 13, 2018
    - PACE Quality Improvement Committee (PACE QIC): August 17, 2018; and September 11, 2018

- QIC Highlights
  - Population Health Management Strategy presented by Betsy Ha was reviewed and approved
  - Longitudinal study for Healthcare Effectiveness Data and Information Set (HEDIS) measures via Tableau demonstration was presented by Kelly Rex-Kimmet. Data captured was used in the development of the 2018 QI Evaluation
  - VSP vision care update to extend to all Medi-Cal Diabetes members presented by Pshyra Jones
  - New 805/National Practitioner Data Bank (NPDB) reporting policy GG.1657 presented by Esther Okajima

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- Q4 Committee and Subcommittee Highlights
    - Behavioral Health QI Committee (BHQIC)
        - The committee reviewed access, member experience, and coordination of care Work Plan elements as well as reviewed BHI related HEDIS measures. In addition, BHI reported on a depression screening initiative. Greatest concern is meeting follow-up after hospitalization HEDIS measures which were below targeted rates.
    - Utilization Management Committee (UMC)
        - The UM Work Plan goals and specific related projects were presented to the committee. Operational performance statistics were shared. Pharmacy & Therapeutics Committee (P&T) and Benefit Management Subcommittee (BMSC) minutes were presented and approved. Projects and initiatives that continue to require resources include Whole-Child Model planning, Multipurpose Senior Services Program (MSSP) transition, and Palliative Care.
    - Long-Term Services and Supports Quality Improvement Subcommittee (LTSS-QISC)
        - Presented operational performance measures results which are on target for Community-Based Adult Services (CBAS) and LTC.
    - Grievance and Appeal Resolution Services (GARS) Subcommittee
        - GARS presented Q3 member and provider complaints in December QIC. GARS minutes submitted that quarter.
    - Credentialing Peer Review Committee (CPRC)
        - The committee continues to review practitioner specific files with issues. Committee also reviews presentations from Audit & Oversight regarding health network credentialing performance, Facility Site Review (FSR), regarding non-compliant sites with failed FSR, medical record review (MRR)and open Corrective Action Plan(s) (CAPS). Presented Department of Health Care Services MRR trend results for 2018. Identified gaps in preventative screening data. Potential Quality Issues (PQI) quality of care cases, and trend summary reports for all health networks, were presented.
    - Member Experience Subcommittee (MEMX)
        - California Association of Health Plans (CAHP) survey results, Customer Service statistics, and Access & Availability subcommittee (A&A) activity were presented to the committee. Updates to Shadow Coaching pilot project and Provider taxonomy code crosswalk were also presented.
    - PACE QIC
        - Presented PACE QIC updates from Q3. Minutes included with QIC minutes.

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Attachments

1. Quality Improvement Committee Meeting Minutes October 09, 2018
2. Quality Improvement Committee Meeting Minutes November 13, 2018
3. Quality Improvement Committee Meeting Minutes December 11, 2018
4. 2018 Quality Improvement Work Plan 3Q QIC
5. PACE Quality Improvement Committee Meeting Minutes May 8, 2018
6. PACE Quality Improvement Committee Meeting Minutes August 7, 2018
7. PACE Quality Improvement Committee Meeting Minutes November 27, 2018

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Quality Improvement Committee
MEETING MINUTES
October 9, 2018
Medi-Cal / One Care / OneCare Connect

Miles Masatsugu, M.D.
Medical Director
Committee Chair

External Voting Members Attending	CalOptima Voting Members Attending	CalOptima Staff Attendees
☒ GORDON, Lowell, M.D., Medical Director FCMG, Pediatrician.	☒ DAJEE, Himmet, M.D., Medical Director, Cardiothoracic Surgeon	☒ ARANDA, Ana, Director, Greivance & Appels
☒ KELLY, John, M.D., * Orthopedic Surgeon, Private Practice	☒ FEDERICO, Frank, M.D.,Medical Director, Hem/Onc	☒ CHOO, Marsha, Manager, Quality and Analytics
☒ KO, Edward, MD Medical Director, AltaMed Health Services	☒ FONDA, Emily, MD, Medical Director, Internal Medicine	☒ FETTERMN, Sharon Director, Utilization Management
☒ MARCHESE, Sarah, MD Medical Director, CHOC Health Alliance, Pediatrician	☐ HITZEMAN, Tracy, Executive Director, Case Management	☒ HA, Betsy, Executive Director, Quality & Analytics & Improvement
☒ MASOUEM, Shahryar, MD Medical Director, Ambulatory Surgery Center, HealthCare Partners Medical Group	☐ LAUGHLIN, Michelle Executive Director Network Operations, CalOptima	☒ GARCIA, Gloria, Program Assistant, Quality Improvement
☒ SINHA, Mohini, M.D. Medical Director, Monarch, Pediatrician	☒ MASATSUGU, Miles, M.D., Medical Director, PACE, Family Medicine	☒ GOMEZ, Veronica, Program Specialist, Int. Quality Improvement
☒ SWEIDAN, Jacob, M.D. Medical Director, Noble, Pediatrician	☐ MUNDUNURI, Sesha, Executive Director, Operations	☒ JONES, Pshyra, Director, Health Education and Disease Management
	☒ SHARPS, Donald, M.D., Medical Director, Behavioral Health, Psychiatrist	☒ OKAJIMA, Esther, Director, Quality Improvement
		☒ POON, Edwin, Director Behavioral Health Services
		☒ REX-KIMMET, Kelly, Director Quality and Analytics
		☒ RAMIREZ, Nicole, Manager Behavioral Health Services
		☒ Zavala, Natalie, Manager Behavioral Health Services

*Full time practitioners

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Quality Improvement Committee
MEETING

Topic	Discussion	Recommendation/Action
Call to Order	Miles Masatsugu, M.D., Committee Chair, called the meeting to order at 12:05 p.m.	No action necessary
Introductions	Introductions were made around the room.	No action necessary
Review and Approval of Minutes	1. Approve the Minutes of the September 11, 2018 CalOptima Quality Improvement Committee (QIC) Meeting The September 11, 2018 meeting minutes were reviewed and approved as presented.	On motion of Dr. Gordon seconded and carried, the Committee approved the September 11, 2018 CalOptima Quality Improvement Committee Meeting as presented.
CMO Update Whole Child Model (WCM) Clinical Advisory Committee Charter	2. Whole Child Model CAC update Emily Fonda, Chief Medical Officer announced that for the 5th year in a row CalOptima was named the number one Health Plan in California.	No action needed.
New Business Population Health Management Strategy	3. Population Health Management Strategy Betsy Ha, RN Executive Director, Quality & Analytics proposed Population Health Management (PHM) Strategy. A copy of the presentation is attached to the original set of these minutes. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span. Addressing the 2018 National Committee for Quality Assurance (NCQA) standards change including a new PHM standard set. CalOptima is aligning disease management programs looking at population with chronic illnesses and not looking at them as individual diseases. The organization has a cohesive plan	Credentialing Department to report on the FSR/MRR/PARS scores with data.

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	of action for addressing member needs across the continuum of care with goals and populations targeted for each of the four areas of focus: Keeping members healthy; Managing members with emerging risk; Patient safety or outcomes across settings; and Managing multiple chronic illnesses. For the area of Patient Safety, a new idea being presented is to improve on patient safety by utilizing practice facilitation team to improve practice health and safety leveraging the QI practice facilitators team. Program goals will be to achieve and sustain 100% compliance of all Facility Site Review (FSR) audits year-over-year for primary care practices. The target population will be Medi-Cal adults and children accessing primary care. Description of programs or services planned to enhance the existing FSR nursing function by training nurses and QI facilitation skills to address any gaps from FSR audit to improve compliance with practice health and safety standards at the practice sites of the CalOptima Community Network (CCN). Activities are to develop practice facilitator functions for the FSR nurses in order to identify opportunities to improve practice site health and safety as well as provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices. In addition, to provide QI technical support to the safety net community clinics, Federally Qualified Health Center (FQHC), and PACE to promote patient safety practices. Committee requested data information on scores for the FSR/MRR/PARS performed. Dr. Marchese shared that CHOC Health Alliance have been conducting similar quality improvement initiatives for the past three years and offered to share with CalOptima some of the best practices, methodology, material etc.to support this new activity.	
VSP Benefit	4. <u>Vision Service Plan (VSP) Benefit</u> Pshyra Jones shared with the Committee on CalOptima's efforts to expand VSP benefits for members with diabetes. Barriers have been identified in member accessing annual eye exams. Currently a member can go to VSP one year and the alternate year go to their health network's affiliated vison provider and sometimes causes confusion to members. 18% of the diabetic population is currently accessing VSP and CalOptima wants to increase eye exam utilization. To improve CalOptima has decided to expand VSP benefits by allowing these members to have annual eye exams at either VSP or their Health Network's affiliated vison provider.	No action needed.
Department/Subcommittee Reports		

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Quality Improvement Committee
MEETING

Utilization Management	5. Utilization Management (UM) Sharon Fetterman, RN, Director, Utilization Management presented Utilization Management Committee (UMC) update. A copy of the report and UMC Committee meeting minutes is attached to the original set of these minutes. UMC found utilization trends to be mostly stable from Q2 2017 to Q2 2018 for all LOBs. There was increase in Medi-Cal Bed days in Q1 2018. One Care Connect and Medi-Cal SPD Readmit rates were consistently above 15% (SPD runs around 23%). Contributing Factors in Q1 2018 was due to large increase in flu related admissions. OCC readmissions are expected in this vulnerable population. UM will assess SPD Transitions of Care processes and continue to monitor for improvement in compliance rate for timeliness. Pharmacy trends are stable with OneCare and OneCare Connect being higher in cost and utilization that in Medi-Cal. Ms. Fetterman deferred Long Term Supports Services (LTSS) utilization to the Long Term Supports Services that will report later in this meeting. Behavioral Health Q2 2018 results for OneCare and OneCare Connect outpatient utilization, data is combined due to low OneCare membership. Outpatient services are managed by Magellan and monitored by CalOptima. The trend is steady for the outpatient utilization. The trend for all lines of service and readmissions is below goals. Bed days and admits per thousand are steady and maintaining a low rate. There are a few 3-4 hospitals in Orange County that handle most psychiatric admissions for OCC. Projects and initiatives updates: 1) The Whole Child Model: The transition plan to Department of Health Care Services (DHCS) is completed. There's ongoing internal and County CCS workgroup meetings. Health Network meetings began July 26, 2018. Multiple future events are planned. CalOptima UM policies and procedures are updated to include Whole-Child Model. 2) Palliative Care: Also known as "Supportive Care" was Implemented 1/1/18. Home and Clinic based services; A total of 119 members (CCN) were offered services as of June 2018. Requiring physician assistant for initiation of program to permit reporting to the State. There's a plan in place to initiate file review. Lastly, minutes for the Physical and Therapy (P&T) Committee and Benefit	On motion of Dr. Gordon seconded and carried, the Committee approved the Utilization Management update as presented.

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	Management Subcommittee (BMSC) were included in the UMC packet for information purposes. The purpose of the BMSC is to review and implement the Operation Instruction Letters (OILs) as well as to assess new benefits and ensure they are configured in our system and revise and update CalOptima's authorization rules as appropriate.	
Behavioral Health QIC	6. Behavioral Health QIC Donald Sharps, MD, Medical Director of Behavioral Health Integration gave an updated to BHQIC. A copy of the report is attached to the original set of these minutes. BHQIC met on 8/28/18. Two new providers joined BHQIC. Updating on Access, Member Experience & Coordination of Care, BH reorganized agenda structure of BHQIC meeting with GARS reported in member experience section. HEDIS BH Measures final rates were presented and PHQ9 update on Adolescent Depression Screening was provided. Behavioral Health (BH) Customer Service metrics met however, barriers to access included provider availability, capacity and location issues. GARS related to access doubled in Q1. Reporting method changed and new provider network for CalOptima Medi-Cal BH provider participation increased for Q2 for Medi-Cal membership. OC/OCC participation reported differently and includes claims review. HEDIS measures & outcomes final 2018 rates demonstrate a flat trend in all measures with one exception. FUH 7-day & 30-day rates declined from the same time last year. ADD & AMM BHI work group claims review, identified top 10 providers/networks for targeted phone campaign and developed Tips sheet for providers. Access, Member Experience & Coordination of Care will track & trend BH provider appointment linkage and monitor GARS data to address providers with multiple complaints HEDIS Measures & Outcomes work group meetings will continue and develop talking points for provider visits by Provider Relations staff as well as prioritize measures to address the continue added efforts with MBHO for options to improve FUH and considering suggestion to add 6 new BH measures to QI work plan	On motion of Dr. Gordon seconded and carried, the Committee approved the Behavioral Health QIC update as presented.
Long Term Supports Services	7. Long Term Supports Services Steven Chang, Director of Long Term Services and Supports provided LTSS Q2 update. UMC measures on operational performance. Community-Based Adult	On motion of Dr. Gordon seconded and carried, the Committee

	Services (CBAS) Eligibility Determination Tool (CEDT) Turnaround Time (TAT) was m with 100% Compliance [CEDT Completion within 30 Days]. Inter-Rater Reliability was also met. CBAS Team Scored 100% Overall [90% is Goal] and LTC Team Scored 95% Overall [90% is Goal]. Number of participants entering or exiting the Multipurpose Senior Services Program (MSSP) was Met with 26 Admissions against 26 Terminations [≤4 Net Loss is Goal]. UMC measures on outcomes, ratio of CBAS Delivered Services vs Authorized as Met with 75.16% (Data is preliminary due to CBAS claims lag). In Q2 2018 zero (0) of OneCare Connect CBAS Members transitioned to Long Term Care. 38 of 5,155 LTC Residents transitioned to the community. Ratio of Members Participating in CBAS vs Potentially Eligible. On the Medi-Cal side there was 2.10% and for OCC there was 1.33%. Ratio of Members Residing in LTC vs Potentially Eligible shows a bit of downwards trend. Medi-Cal was at 3.94% where OCC was 2.70%. Next steps: LTC Hospital Readmissions Reduction Workgroup on infection control research and study with hope to partnership CalOptima and physicians and introduce new processes to decrease infections. Also working on Antibiotics Stewardship. MSSP transition was planned for 2020 however delay was requested and transition in now planned for 2021. CBAS trainings and outreach to increase members in CBAS by planning voluntary trainings with Health Networks and outreach to potentially eligible members as well as members that stopped going to CBAS. Lastly, LTSS will continue to look at baseline references and comparisons for LTSS Measures.	approved the Long Term Supports Services update as presented.
Grievance and Appeals	8. <u>Grievance and Appeals Resolution Services(GARS)</u> Ana Aranda, Interim Director, Grievance and Appeals Resolution Services presented GARS update. A copy of the report is attached to the original set of these minutes. **Medi-Cal Complaints** in Q2, 2018 increased across the board many due to new categorization at the point of intake and a majority 67% are Quality of Service complaints that include delay in service, provider service and rudeness. A Provider Data Initiative workgroup is working towards improving the provider data which is critical for referrals and authorizations. **OneCare Connect Complaints** had a slight increase in Q2, 2018. 88% were identified as Quality of Service that includes delay of service, provider services, and transportation	On motion of Dr. Gordon seconded and carried, the Committee approved the Grievance and Appeals Update as presented

	vendor. The transportation vendor, American Logistics, continues to train their drivers and dispatchers in providing better service to members. GARS referred provider trends to CalOptima's Provider Relations department for further review and action necessary. **OneCare Member Complaints** have been stable no trends to report.	
Program for All-Inclusive Care for the Elderly	9. Program for All-Inclusive Care for the Elderly Miles Masatsugu, MD provided QIC PACE Q2 2018 QI Work Plan Update. A copy of the report is attached to the original set of these minutes. Membership is at pace is currently at 293. POLST rate is at 100% for all PACE members however there's a challenge in POLST utilization when a member is hospitalized. The barrier is thought to be family members becoming more involved during hospitalization than pre-hospitalization. PACE will revisit POLST workflow to improve on utilization at hospitals. Medication Reconciliation Post-Discharge (MRP) has increased due to post hospital follow up performed 1-2 days after hospital discharge. Hospital Bed Days (Goal: <2,590 Hospital Days/K/Year) had improved despite having a bad flu season this past year. 30-Day All-Cause Readmissions (<12.5%, 2016 CalPACE Average) has held steady in the last quarter with rate just under the goal. There was a CMS/DHCS audit was completed in April and May of 2018 with findings of service delivery requests, personnel files, and IDT Assessments. The overall score was 2.20. Corrective action plan was submitted and accepted. Audit remediation taking place. More detailed report will be shared next quarter. PACE will focus to implement audit remediation, revisit POLST workflow, look into ER diversion implementation and complex case management. And continue Alternative Care Settings (ACS) and PACE Community PCPs Expansion	On motion of Dr. Gordon seconded and carried, the Committee approved the Program for All-Inclusive Care for the Elderly Update as presented
QI Work Plan Dashboard -Q2	10. QI Work Plan Dashboard -Q2 Esther Okajima Director, Quality Improvement presented 2018 QI Workplan Dashboard - Quarter 2. A copy of the workplan is attached to the original set of these minutes. Q2 goals that are of concerns or at risk in Program Oversight are OCC Quality Withhold measure for MY2017, which is expected to be at 75%. It's related to Follow-up after Hospitalization Measure which failed in DY2 and DY3. OC/OCC Model of Care metrics are still in process of being updated and captured with the QI Workplan. Will finalize reporting by 10/31/18. Quality of Clinical Care (CM): One Care Initial Health Risk Assessment (HRA) collection rate is below its target of 78%. CalOptima is considering addition of new questions in HRA to promote engagement. Satisfaction with Case Management is below target of 88%	On motion of Dr. Gordon seconded and carried, the Committee approved the QI Work Plan Dashboard -Q2 Update as presented

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	and are reevaluating resources and providing additional support and training. Coordination of CCS Medical Home and CalOptima PCP is below goal of 90%. oving to report on goals for Quality of Clinical Care. Behavioral Health Interdisciplinary Care Team (ICT) participation is low (44%) however, BH is working through barriers to participation. Long Term Supports Services (LTSS) overall ratio of average CBAS utilization vs. approved was below target of 80%. LTSS is monitoring ratio of members participating in CBAS versus potentially program-eligible. HEDIS Measures (17 measures total) of which BH Follow-up after hospitalization after 7 and 30 days were at risk. Safety of Clinical Care timely completion of full scope FSR/MRR within three years and Timely closure of Potential Quality of Care cases within 90 days are not being met. Quality of Service: CAHPS scores at or below the 25th percentile for Adult Medicaid, including scores for Getting Care Quickly, Getting Needed Care, and Rating of Health Plan, and Customer Service. Customer Service First Call Resolution targets was not met for MC, OC, OCC and is at risk. Network Adequacy: Credentialing processing times exceed target of 120 days is at risk.1 practitioner file exceeded 36 month re-credentialing requirements. Timely access standards for specialty care not met. In Compliance Several Health Networks have not meet goal of 98% for Utilization Management, Credentialing and Claims. Results are presented at CalOptima's Audit Oversight Committee and corrective action plans are issued for performance improvement. All measure in QI Work plan that were either not met or at risk are being addressed and tracked. A report on the goals will be presented at next quarter.	
Open Discussion	No open discussion.	No action necessary
Approval of attachments	• QIC Meeting Minutes_09.11.2018_Draft • QIC 10 09 2018 PPT • UMC MEETING MINUTES_05 24 2018_DRAFT • BMSC Meeting Minutes 4.25.18_final • BMSC Meeting Minutes 5.30.18_final • BMSC Meeting Minutes 6.27.18_final • 10-4-18 BHQIC DRAFT mins • MINUTES-September 17 2018 LTSS QISC v2 • GARS Committee Minutes Q1 2018 05.31.18_FINAL • PQIC Meeting Minutes 2018 Q2 March 13 2018 • PQIC Meeting Minutes May 8 2018 • PQIC Meeting Minutes 2018 Q2 June 12 2018	On motion of Dr. Marchese seconded and carried, the Committee approved the submitted attachments as presented.

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Quality Improvement Committee
MEETING

	• 2018 QI Workplan 2Q_QIC_Final_10.9.18	
Next Meeting	November 13, 2018 • Clinical Operations Population Health • Quality Analytics • Credentialing Peer Review	No action necessary
Adjournment and Next Meeting	There being no further business before the Committee, the meeting was adjourned at 1:25 p.m.	Dr. Masatsugu adjourned the meeting.

Respectfully Submitted:

David Ramirez M.D., Chief Medical Officer — Date: 11/13/18

Recorded by: Gloria Garcia, QI Program Assistant

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Quality Improvement Committee
MEETING MINUTES
November 13, 2018
Medi-Cal / One Care / OneCare Connect

David Ramirez, M.D.
Chief Medical Officer
Committee Chair

External Voting Members Attending	CalOptima Voting Members Attending	CalOptima Staff Attendees
☒ GORDON, Lowell, M.D., Medical Director FCMG, Pediatrician.	☒ DAJEE, Himmet, M.D., Medical Director, Cardiothoracic Surgeon	☒ AURELIO, Jose Manager, Quality and Analytics
☐ KELLY, John, M.D., * Orthopedic Surgeon, Private Practice	☒ FEDERICO, Frank, M.D.,Medical Director, Hem/Onc	☒ FETTERMN, Sharon Director, Utilization Management
☒ KO, Edward, MD Medical Director, AltaMed Health Services	☐ FONDA, Emily, MD, Medical Director, Internal Medicine	☒ HA, Betsy, Executive Director, Quality & Analytics & Improvement
☒ MARCHESE, Sarah, MD Medical Director, CHOC Health Alliance, Pediatrician	☐ HITZEMAN, Tracy, Executive Director, Case Management	☒ GARCIA, Gloria, Program Assistant, Quality Improvement
☐ MASOUEM, Shahryar, MD Medical Director, Ambulatory Surgery Center, HealthCare Partners Medical Group	☒ LAUGHLIN, Michelle Executive Director Network Operations, CalOptima	☐ GOMEZ, Veronica, Program Specialist, Int. Quality Improvement
☐ SINHA, Mohini, M.D. Medical Director, Monarch, Pediatrician	☐ MASATSUGU, Miles, M.D., Medical Director, PACE, Family Medicine	☒ JONES, Pshyra, Director, Health Education and Disease Management
☒ SWEIDAN, Jacob, M.D. Medical Director, Noble, Pediatrician	☐ MUNDUNURI, Sesha, Executive Director, Operations	☒ OKAJIMA, Esther, Director, Quality Improvement
	☒ RAMRIEZ, David, M.D., Chief Medical Director, Internal Medicine	☐ POON, Edwin, Director Behavioral Health Services
	☐ SHARPS, Donald, M.D., Medical Director, Behavioral Health, Psychiatrist	☒ REX-KIMMET, Kelly, Director Quality and Analytics
		☒ HERRERA, Monica, Director, Audit & Overisight
		☒ KANJAU, Paul Data Analyst, Int Quality Analytics
		☒ NOYES, Katherine, Supervisor, Quality Improvement

*Full time practitioners

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Quality Improvement Committee
MEETING

Topic	Discussion	Recommendation/Action
Call to Order	Dr. Ramirez, M.D., Committee Chair, called the meeting to order at 12:05 p.m.	No action necessary
Introductions	Introductions were made around the room.	No action necessary
Review and Approval of Minutes	1. Approve the Minutes of the October 09, 2018 CalOptima Quality Improvement Committee (QIC) Meeting The October 09, 2018 meeting minutes were reviewed and approved as presented.	On motion of Dr. Gordon seconded and carried, the Committee approved the October 09, 2018 CalOptima Quality Improvement Committee Meeting as presented.
Old Busines DHCS Medical Record Review Results	2. DHCS Medical Record Review Results Esther Okajima, QI Director provided a follow-up to 10/09/18 action to report on FSR/MRR/PARS scores with data. There were 201 Full Scope FSR completed year to date, which exceeds the total completed in 2017. In the last 3 quarters, the majority of the sections score about 80%, however, the one area that consistently scores below 80% in Q1-Q3 is the adult preventative measures. Examples of the questions that score below 80% include: 1) IHA 2) Staying healthy assessment (initial and subsequent) 3) Periodic Health Evaluations 4) TB Screening 5) Breast Cancer Screening 6) Cervical Cancer Screening 7) Colorectal Screening 8) Adult Immunizations Next steps are to conduct a Practice Site visit with CHOC Health Alliance. There is planned collaboration with cross-functional areas such as QA/HE/PR/BH to improve scores. FSR Nurses will participate in Quality Initiatives Work Teams. Provider training will also be conducted with CCN/HN.	No action needed.

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Quality Improvement Committee
MEETING

New Business Population Health Management Strategy-Review and Approval	3. Population Health Management Strategy Betsy Ha, RN Executive Director, Quality & Analytics proposed Population Health Management (PHM) Strategy for approval. A copy is attached to the original set of these minutes. PHM was presented and conceptual framework, roadmap and timeline along with areas of focus and the intent and approach were presented. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span. 2018 National Committee for Quality Assurance (NCQA) standards change includes a new PHM standard. CalOptima is aligning disease management programs looking at population with chronic illnesses and not looking at them as individual diseases. The organization has a cohesive plan of action for addressing member needs across the continuum of care with goals and populations targeted for each of the four areas of focus.	On motion of Dr. Sweidan seconded and carried, Population Health Management Strategy was approved.
Department/Subcommittee Reports Credentialing Peer Review Committee Updates	4. Credentialing Peer Review Committee (CPRC) Q3 Update Esther Okajima, QI Director presented CPRC Q3. update. A copy of the report is attached to the original set of these minutes. CPRC met on 7/19/18, 8/23/18, 9/27/18, reviewed Credentialing of Practitioners & HDO's; Facility Site Review (FSR)(s) /Medical Records Review(MRR)(s)/Physical Accessibility Review(s)(PARS); Potential Quality of Care(PQI)(s); Ongoing Monitoring of Providers; HN Credentialing File Review by A&O; and Policy Review GG.1611 and GG.1612. Year to date volume exceeds total for 2017 and experienced a double in size of network in 2018. Majority of activity is recredentialing, although initials are stead due to increase network of CCS paneled providers. Average Turnaround times are approximately 120 days, however some files are taking greater up to 180 days, some files are completed in less than 90. Credentialing is currently experiencing a backlog of files, where more than 50% of the files take more than 120 days to complete. Credentialing is working with Contracting and Provider	On motion of Dr. Gordon seconded and carried, the Committee approved the Utilization Management update as presented.

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Quality Improvement Committee
MEETING

Quality Analytics	Relations to determine priorities to ensure critical practitioners are being processed timely. Credentialing and Enrollment next step is to streamline processes to reduce TAT for processing files. Includes implementation of new provider application and working with Contracting and PR to determine priorities to ensure critical practitioners are being processed timely. 201 Full Scope FSR's have been completed in 2018, which exceeds total completed in 2017. Experienced a backlog in Q1 and Q2 with 22% of the oversites were performed >3 years. With additional staff, was able to reduce to only 7% overdue in Q3. Experiencing issues with providers not closing their CAPS timely, resulting in 5% panel closures to new members in Q3. As stated earlier, seeing an increase in failed scores for full-scope reviews, 7% in failed scores in Q3. FSR/MRR will align with Quality Initiative teams to look for opportunities to improve adult preventative measures at practice sites. Share data and conduct training with Health Networks to raise awareness of ongoing issues and opportunities. 5. Quality Analytics- Tableau Demo Kelly Rex-Kimmet, Director of Quality Analytics presented a demonstration of Tableau, an interactive visual analysis product that can combine data without writing code and capable to connect and extract data live.	No action necessary.
Open Discussion	No open discussion.	No action necessary
Approval of attachments	• QIC Meeting Minutes_10.09.2018_Draft • QIC 11 13 2018 PPT • Population Health Management Strategy_Final_ Reviewed by Communication_and QIC_to QAC_10_26_18 • MRR Report Q3 2018- Trend Summary All Network	On motion of Dr. Marchese seconded and carried, the Committee approved the submitted attachments as presented.
Next Meeting	December 11, 2018 • Member Experience • Grievance and Appeals Resolution Services • PACE • QI Work Plan Dashboard	No action necessary
Adjournment and Next Meeting	There being no further business before the Committee, the meeting was adjourned at 1:15p.m.	Dr. Ramirez adjourned the meeting.

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Quality Improvement Committee
MEETING

Respectfully Submitted:

Miles Masatsugu M.D., Medical Officer — 12-11-18 Date

Recorded by: Gloria Garcia, QI Program Assistant

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Quality Improvement Committee
MEETING MINUTES
December 11, 2018
Medi-Cal / One Care / OneCare Connect

David Ramirez, M.D.
Chief Medical Officer
Committee Chair

External Voting Members Attending	CalOptima Voting Members Attending	CalOptima Staff Attendees
☒ GORDON, Lowell, M.D., Medical Director FCMG, Pediatrician.	☒ DAJEE, Himmet, M.D., Medical Director, Cardiothoracic Surgeon	☒ ARANDA, ANA, Director, Grievance and Appeals
☒ KELLY, John, M.D., * Orthopedic Surgeon, Private Practice	☐ FEDERICO, Frank, M.D.,Medical Director, Hem/Onc	☐ FETTERMN, Sharon Director, Utilization Management
☐ KO, Edward, MD Medical Director, AltaMed Health Services	☐ FONDA, Emily, MD, Medical Director, Internal Medicine	☐ HA, Betsy, Executive Director, Quality & Analytics & Improvement
☒ MARCHESE, Sarah, MD Medical Director, CHOC Health Alliance, Pediatrician	☐ HITZEMAN, Tracy, Executive Director, Case Management	☒ GARCIA, Gloria, Program Assistant, Quality Improvement
☒ SINHA, Mohini, M.D. Medical Director, Monarch, Pediatrician	☐ LAUGHLIN, Michelle Executive Director Network Operations, CalOptima	☒ GOMEZ, Veronica, Program Specialist, Int. Quality Improvement
☒ SWEIDAN, Jacob, M.D. Medical Director, Noble, Pediatrician	☒ MASATSUGU, Miles, M.D., Medical Director, PACE, Family Medicine	☐ JONES, Pshyra, Director, Health Education and Disease Management
	☐ MUNDUNURI, Sesha, Executive Director, Operations	☒ OKAJIMA, Esther, Director, Quality Improvement
	☒ RAMRIEZ, David, M.D., Chief Medical Director, Internal Medicine	☐ POON, Edwin, Director Behavioral Health Services
	☒ SHARPS, Donald, M.D., Medical Director, Behavioral Health, Psychiatrist	☒ REX-KIMMET, Kelly, Director Quality and Analytics
		☒ CHOO, MARSHA, Manager Quality Analytics
		☒ Eva Elser, Manager, PACE

Topic	Discussion	Recommendation/Action

*Full time practitioners

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Quality Improvement Committee Meeting

Call to Order	Dr. Ramirez, Committee Chair, called the meeting to order at 12:11 p.m.	No action necessary
Introductions	Introductions were made around the room.	No action necessary
Review and Approval of Minutes	1. Approve the Minutes of the November 13, 2018 CalOptima Quality Improvement Committee (QIC) Meeting The November 13, 2018 meeting minutes were reviewed and approved as presented.	On motion of Dr. Gordon seconded and carried, the Committee approved the November 13, 2018 CalOptima Quality Improvement Committee Meeting as presented.
New Business Policy GG.1657	2. Policy GG.1657 Esther Okajima, Director, Quality Improvement presented Policy GG.1657. A copy is attached to the original set of these minutes. New policy outlines requirements for reporting 805 and 805.01 to MBOC as well as NPDB reporting. It includes outlines and timelines of the reporting requirements. Health Networks also are required to report to CalOptima within 30 days any reporting of 805 and/or 805.01.	On motion of Dr. Sweidan seconded and carried, Policy GG.1657 was accepted and filed.
Department/Subcommittee Reports Member Experience	3. Member Experience Sub-Committee Quarter 3-2018 Marsha Choo, Manager, Quality Improvement provided an update. A copy of the report is attached to the original set of these minutes. Access and Availability Sub-Committee met and discussed timely access. CalOptima has engaged in a DHCS Audi with focus on timely access to care. QIPs: Revised QIPs for this year to be more prescriptive. In past years, CalOptima has issued QIPs and/or corrective action plans (CAPs) and health network actions submitted were not robust enough to improve. QIPs will ask the health networks what they are currently doing to improve timely access to care. And it will list interventions for health networks to perform, including outreach to non-compliance providers and auditing of newly contracted providers. They will be issued in December 2018.	On motion of Dr. Gordon seconded and carried, the Committee approved the Member Experience Sub-Committee update as presented.

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	Mystery Shopper: To better monitor appointment availability, the Timely Access Survey will include a mystery shopper data collection methodology, where staff from a contracted vendor will call providers offices and ask for their next available appointment. This will allow CalOptima to obtain data from all contracted providers and also allow CalOptima to provide comprehensive provider performance data to the health networks. The Timely Access Survey will still include a paper survey for the providers, as we cannot use this methodology to capture all elements required. Timely Access Survey will be fielded in Q1 and Q2 of 2019. DHCS: For 2018, CalOptima submit files and documents to our regulatory entities to determine whether they meet network adequacy standards. DHCS moved to Network Certification of Health Plans. All standards were met at the plan level, but not all standards were met at the health network level. We plan to work with the health networks to improve this area. The next Network Certification is due in March 2019 and we are awaiting an updated All Plan Letter from DHCS. There are concerns as OCA is terming and MC provider are required to be Medi-Cal enrolled. However, we have conducted preliminary analysis that suggests that CalOptima should me the network adequacy standards. Also DHCS just released a draft network certification checklist and a taxonomy crosswalk in Nov 2018. The difference from the last year is that DHCS, rather than CalOptima, will now be using the monthly submitted provider file (274 file) to roll up the counts of required providers based on the taxonomy crosswalk. CalOptima met all network adequacy standards at the plan level for all lines of business however, not all standards were met at the health network level. DHCS network certification is anticipated in March 2019. Preliminary analysis suggests that CalOptima should meet DHCS network adequacy standards when excluding OCA providers and providers who are not Medi-Cal enrolled. DHCS released network certification checklist and taxonomy crosswalk in November 2018. Field CG-CAHPS (provider level member experience survey) in Q1 and Q2 of 2019. CG-CAHPS: CalOptima contracted with a new vendor to field CG-CAHPS. Surveying members about their most recent visit and data rolled up by provider. Each provider will receive a provider report card. Referrals and Authorizations: Member Experience Sub-Committee has been reviewing member experience data (ie. CAHPS, grievances, etc) and have identified referral and authorizations as an area of focus for 2019. They have	

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	engaged the UM department and launched a workgroup that will focus on improving member experience in this area. Provider Coaching update: There is lots of interested from health networks for both shadow coaching and the customer service workshops. There were 6 shadow coaching completed and 5 are planned in December 2018. There's also a Lunch and Learn in December for CCN.	
Grievance and Appeals Resolution Services	4. Grievance and Appeals Resolution Service Ana Aranda, Director GARS met, Director of Grievance and Appeals Resolution Services presented the Member and Provider Complaints 3Q, 2018 data. There was a slight decrease in all grievances received in Q3-2018. CalOptima received 5,604 Medi-Cal complaints in Q3-2018 of those 307 were Member Appeals; 4,214 Member Grievances; and 1,083 Provider Appeals. Grievances by Category: 65% for Quality of Service that includes: • Delays in service • Provider services • Transportation (NMT) Services 13% for Access that includes: • Appointment availability • Specialty care referrals • Telephone accessibility 19% for Billing that includes: • Reimbursement requests • Urgent care visits • Out of network services 3% for Quality of Care issues CalOptima received 437 OneCare Connect Complaints in Q3-2018 of those 101 were Member Appeals: 235 Member Grievances: and 101 Provider Appeals. 87% of grievances were for Quality of Service that includes: • Delays in service • Issues with Primary Care Physician • Wrong information provided CalOptima received 26 OneCare complaints in Q3.-2018 of those 7 were Member Appeals; 13 Member Grievances; 6 Provider Appeals.	On motion of Dr. Gordon seconded and carried, the Committee approved the GARS update as presented

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Quality Improvement Committee Meeting

QI Work Plan Q3	5. QI Work Plan Q3 Esther Okajima presented 2018 QI Workplan Dashboard - Quarter 3, 2018. A copy of the Work Plan is attached to the original set of these minutes. In summary, 124 measures total, 8 retired, out of 116 remaining measures 3% are at risk; 30% have concerns; and 67% are on Target. For Program Oversight the Clinical Operations Population Health Subcommittee (COPHS) reporting structure was found to have challenges reporting elements thru COPHS and as a result, in 2019 elements will be reported directly to QIC and COPHS will be eliminated. Quality of Clinical Care • CM - OC Initial HRA collection rate below target of 78% at 63%, similar to Q2 performance. Looking at other ways to promote engagement. • CM - Coordination of CCS Medical Home and CalOptima PCP below goal of 90%. Currently at 50%, looking at barriers to achieving goal. With the delay of WCM to 7/1/2019, planning underway to achieve alignment by go-live. • LTSS – Ratio of members participating in CBAS versus potentially program-eligible decreased by 6% from Q2. Also ratio of members in LTC increased by 13% from Q2. • HE/DM – IHA completion rate is slightly less that previous quarter and is not meeting goal of improvement. Next step is to share results with clinics. HEDIS Measures • BH Follow-up after hospitalization after 7 and 30 days continue to be below goal. However the prospective rates display improvement over this time last year in this measure. • Comprehensive Diabetes Care (Exam and Nephrology) below target however appear to be performing better than results from this time last year. • 15 additional measures currently tracking and monitoring Safety of Clinical Care • Timely closure of Potential Quality of Care cases within 90 days not meeting target. Looking for trends within the data to address member pain points. Compliance • Monitor HN performance and report to AOC. For HN that do not meet goals, issue CAPs and follow-up as required Quality of Service • CAHPS scores at or below the 25th percentile for Adult Medicaid, including scores for Getting Care Quickly, Getting Needed Care, Customer Service and Care Coordination. Provider Coaching intervention in progress to help improve this area.	On motion of Dr. Gordon seconded and carried, the Committee approved the QI Work Plan Q3.2018 update as presented

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Quality Improvement Committee Meeting

	• Customer Service continues to work on improving member experience through improvements in average speed of answer, and abandonment rate. Network Adequacy • Credentialing processing times exceed target of 120 days. Currently about 50% are completed within 120 days. Working on improving E2E processes to reduce backlog of files that require credentialing ➢ 3 Practitioner File exceeded 36-month re-credentialing requirements • Timely access standards for specialty care not met. Issuing Quality Improvement Plans (QIPs) in December CalOptima will be evaluating 2018 QI Program utilizing trend data over last five years and determine the effectiveness of QI activities and interventions as appropriate. Evaluation categories include Quality of Clinical Care, Safety of Clinical Care, Member Experience, and Network Experience. The Evaluation will be presented at next QIC. In addition, CalOptima will utilize evaluation results to inform 2019 program and workplan. New QI Committee Structure will be simplified. QI Workplan goals will be SMART and data-informed. QI Workplan will be simplified and focused, Maintenance of business goals will not be included in the workplan. QI Program and Workplan will be presented at next QIC.	
PACE QIC	6. <u>Program for All Inclusive Care of the Elderly (PACE)</u> Dr. Masatsugu presented the PACE August and September meeting minutes for Committee to accept and file.	On motion of Dr. Gordon seconded and carried, the Committee accepted and filed PACE minutes as presented.
Open Discussion	No open discussion.	No action necessary
Approval of attachments	• QIC Meeting Minutes_11.13.2018_Draft • QIC 12 11 2018 PPT • GG.1657PP_PRC20181115-20_v.TBD_QIC20181211_FINAL PACKET • Member Experience Team Minutes_09.18.18_Approved • Member Experience Team Minutes_2018.10.02_Approved • Member Experience Team Minutes_2018.10.16 Approved • Member Experience Team Minutes_2018.11.13_Draft • GARS Committee Minutes Q2 2018 08.30.18-SIGNED	On motion of Dr. Marchese seconded and carried, the Committee approved the submitted attachments as presented.

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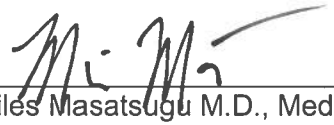
Quality Improvement Committee Meeting

	• 2018 QI Workplan 3Q_12.11.18_QIC • 7. PQIC Minutes August 2018_Final 09272018 • 11. PQIC Minutes September 11 2018	
Next Meeting	January 08, 2019 • 2018 QI Program Evaluation • 2019 QI Program and Work Plan • Utilization Management update • Behavioral Health QISC update	No action necessary
Adjournment and Next Meeting	There being no further business before the Committee, the meeting was adjourned at 1:29p.m.	Dr. Ramirez adjourned the meeting.

Respectfully Submitted:



Miles Masatsugu M.D., Medical Officer

1/7/19

Date

Recorded by: Gloria Garcia, QI Program Assistant

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#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
I. PROGRAM OVERSIGHT											
1	QIC	Qua ity Improvement	Esther Okajima/Kelly Rex-Kimmet	2018 QI Annual Oversight of Program and Work Plan	Approve QI Program and Workplan for 2018	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Descritpion-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018	None	3/1/2018	
2	QIC	Qua ity Improvement	Esther Okajima/Kelly Rex-Kimmet	2017 QI Program Evaluation	Evaluate QI Program for 2017	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018	None	3/1/2018	
3	QIC	Ut ization Management	Tracy Hitzeman	2018 UM Program and UM Workplan	Approve UM Program and Workplan for 2018	UM Program and UM Work Plan will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018-(UM Pogram Only)	Work Plan will go in 2Q to QIC	3/1/2018	
4	QIC	Ut ization Management	Tracy Hitzeman	2017 UM Program Evaluation	Evaluate UM Program for 2017	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation	Approved at UMC 3/22/2018; QIC 4/10/2018; QAC 5/16/18: Wi l go to BOD 6/7/2018	QIC Approved April 10th meeting.	4/1/2018	
5	QIC	Case Management	Sloane Petrillo	2018 Case Management Program	Approve CM Program for 2018	CM Program will be adopted on an annual basis; Delegation oversight reported by DOC	Annual Adoption	CM Program on target to present at QIC.	QIC approved May 8th Meeting.	5/8/2018	
6	QIC	HE & DM	Pshyra Jones	2018 Health Management Program	Approve HM program for 2018	HM Program will be adopted on an annual basis	Annual Adoption	Approved at QIC 2/13/2018	None	2/13/2018	
7	QIC	Qua ity Improvement	Esther Okajima	Credentialing Peer Review Committee Oversight	Peer Review of 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	CPRC presented 2Q results will be presented to QIC 7/17/2018.	3Q results wi l be presented to QIC 10/9/2018.	12/31/2018	
8	QIC	Behavioral Health	Donald Sharps MD	BHQIC Oversight	Internal and External oversight of BHI Activities	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	BHQIC 2Q was presented to QIC on 7/17/2018. **Completed for 2018**	3Q results were presented to QIC 10/9/2018. **Completed for 2018**	4Q	
9	QIC	Ut ization Management	Sharon Fetterman	UMC Oversight	Internal and External oversight of UM Activities	UMC meets quarterly; it monitored medical necessity cost-effectiveness of care and services reviewed utilization patterns monitored over/under-uti ization and reviewed inter-rater reliability results	Quarterly Adoption of Report	UMC 2Q was presented to QIC 7/17/18 .	3Q results were presented to QIC 10/9/2018.	4Q	

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10	QIC	Qua ity & Analytics	Kelly Rex-Kimmet	Member Experience SubCommittee Oversight	Oversight of Member Experience activities to improve member experience	The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys monitor the provider network including access & ava lability (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	MEMX 2Q was presented to QIC 9/11/2018.	3Q results wi l be presented to QIC 12/11/2018.	4Q	
11	QIC	LTSS	Steven Chang	LTSS QISC Oversight	LTSS QI Oversight	The LTSS Quality Improvement Sub Committee meets on a quarterly basis and addresses key components of regulatory safety quality and clinical initiatives.	Quarterly Adoption of Report	LTSS 2Q was presented to QIC on 7/17/2018.	3Q will be presented to QIC on 10/9/2018.	Q4	
12	QIC	Medical Affairs	Tracy Hitzeman/ Betsy Ha	Clinical Operations/Population Health Oversight	Clinical Operations Oversight	This COPHS monitors the progress of the established program goals and metrics defined for CalOptima's disease management complex case management programs and Model of Care.	Quarterly Adoption of Report	In Q3 it was determined that it was best to have programs related to disease management complex case manaegment and models of care report directly to QIC through the workplan as well as to QIC directly. After Q4 a recommendation wi l be made to dissolve the Clinical Operation Population Health Sub-committee and move to meet as a workgroup throught the existing Clinical Process Excellence group.	Reports will occur in subgroupas and through the QI Workplan and QIC as needed	Q4	
13	QIC	GARS	Ana Aranda	GARS Committee	GARS Committee Oversight	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	GARS Committee meeting scheduled for 11/29/18 to review Q3 2018 data. Presented Q2 2018 to QIC 10/9/2018. No outstanding issues.	Q3 will be presented to QIC on 12/11/2018	4Q	
14	QIC	PACE	Dr. Miles Masatsugu	PACE QIC	PACE QIC Oversight	The PACE QIC oversees the activities and processes of the PACE center. Reseults are presented to PACE-QIC	Quarterly Adoption of Report	PACE will be taking 3Q udpates to the 12/11 QIC meeting along with 3Q minutes.	3Q will be presenting to QIC on 12/11/2018	4Q	
15	QIC	Qua ity & Analytics	Esther Okajima/Kelly Rex-Kimmet	Quality Program Oversight - NCQA	Maintain "Commendable" NCQA accreditation rating	Monitor specific HEDIS measures listed below. Conduct NCQA Renewal Survey submission May 2018	Maintain Commendable Status. Accreditation evaluated every three years. HEDIS measures scored annually.	Submission was on May 22 2018. On-Site Audit was on July 9-10.	Submitted on by May 22. On 8/2018 we received Commendable Status.	8/31/2018	
16	QIC	Qua ity & Analytics	Kelly Rex-Kimmet/ Esther Okajima	Quality Program Oversight - Health Plan Rating	Maintain or exceed NCQA 4.0 health plan rating	Monitor specific HEDIS measures listed below and Maintain Commendable Status.	Achieve 4.0 Health Plan Rating - Annual Assessment	We achieved 4.0 Health Plan Rating 5 years in a row.	Health Plan Ratings were received we were scored top rated in Ca ifornia.	9/30/2018	
17	QIC	Qua ity & Analytics	Kelly Rex-Kimmet/ Tracy Hitzeman	Quality Program Oversight - Qua ity Withold	Earn Quality Withhold Dollars back for OneCare Connect in OCC QW program.	Quarterly monitoring and reporting to OCC Steering Committee and QIC	Annual Assessment	Reported to OCC Sterring committee 8/30/18 on CalOptima performance and distribution of withhold based on 2016 (demonstration year 2) performance. Continue to monitor YTD performance on OCC quality withhold measures. Expected earn back is currently at 50% of withhold. Follow-up after Hospitalization (FUH) for Mental Illness Interaction with Care Team at risk for not meeting estab ished benchmarks.	Await final 2017 OCC Quality Withhold passing percentage from CMS. Discuss continued risk of the FUH measure with BH team.	4Q	

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18	QIC	Qua ity & Analytics	Kelly Rex-Kimmet/ Sandeep Mital	Pay for Value	• Implement and monitor health network performance on P4V measures during the year; • Calculate and distribute the P4V incentive payments to participating health networks for MY 2017; and • Calculate and distribute the P4V incentive payments to participating providers in CCN for MY 2017	• Generate and share Prospective Rate reports monthly for a l health networks on their performance on adult and child clinical measures • Complete review of 2017 measures at the end of the year • Hold provider education with Provider relations team to educate CCN providers and provider relations team on the new CCN P4V program. • Implement CCN P4V Prospective Rate reporting	National and State benchmarks	CCN Lunch and Learn in September presented additional education to CCN providers about the CCN P4V program and CCN P4V provider report cards. HN P4V scores and payments based on 2017 performance habve been calculated.	Present HN P4V payments to HNs 12/10/18. Calculated CCN P4V scores and payments. CCN P4V distribtions planned for Q1 2019. Delay due to receipt of OCC HN CAHPS results from vendor.	4Q	
19	QIC	Medical Affairs	Tracy Hitzeman/ Betsy Ha	MOC Dashboard 2016-2019	Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter 2018 ; Re-evaluate measurements through data analysis	Define analytics and resources to support the Model of Care for OC/OCC & SPD members; Implement activities to meet or exceed measures	Meet or exceed defined MOC Metrics	The MOC elements will be reported on the QIPE/PIPE and submitted as needed through the QI Workplan	Monitor through QI workplan reports	12/31/2018	
	II. QUALITY OF CLINICAL CARE - CARE MANAGEMENT										
20	QIC	Case Management	Sloane Petrillo	Review of Health Risk Assessments for OCC New Beneficiaries	OCC- Health Risk Assessment Outreach for members in the OneCare Connect Program monitored for completion and collection for Initial HRA	OCC- Administer the initial HRA to the high risk beneficiary within: 45 days of a beneficiary's enrollment OCC- Administer the initial HRA to the low risk beneficiary within: 90 days of a beneficiary's enrollment	OCC High Risk Initial: 56% OCC Low Risk Initial: 43%	OCC High Risk Initial: 74% collected (Quarter 3) OCC Low Risk Initial: 65% collected (Quarter 3)	Continue to monitor for sustained improvement.	12/31/2018	
21	QIC	Case Management	Sloane Petrillo	Review of Health Risk Assessments for OC New Beneficiaries	OC- Health Risk Assessment Outreach for members in the OneCare Program monitored for completion for Initial HRA	OC - Administer the Initial HRA within 90 days of beneficiary eligibility.	For OC Initial HRA - Achieve Collection Rate of 78% report quarterly	OC Initial HRA: 63% collected (Quarter 3)	Plan to expand redesigned HRA and add new question to HRA to promote engagement. Evaluate staffing and backup for OC HRA collection. Consider appropriateness of target.	12/31/2018	
22	QIC	Case Management	Sloane Petrillo	Review of Health Risk Assessments for SPD New Beneficiaries	SPD- Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion for Initial HRA	SPD- Administer the initial HRA to the high risk beneficiary within: 45 days of a beneficiary's eligibility; SPD- Administer the initial HRA to the low risk beneficiary within: 105 days of a beneficiary's eligibility	For SPD Initial High Risk HRA - Achieve Collection Rate of 63% report quarterly	SPD High Risk Initial: 65% collected (Quarter 3) SPD Low Risk Initial: 59% collected (Quarter3)	Redesigned HRA seems to flow better. Results consistent with prioir quarter. Will continue to monitor results of addition of new question designed to promote engagement.	12/31/2018	
23	QIC	Case Management	Sloane Petrillo	Annual Collection and Review of Health Risk Assessments for OCC/ OC/ SPD existing members	OCC/OC/SPD: Administer the annual HRA to the beneficiary to all participants	OCC/OC/SPD: Administer the annual HRA to the beneficiary to all participants	OCC Annual: 50% OC Annual: 34% No goal set for SPD.	OCC Annual: 65% collected (Quarter 3) OC Annual: 45% collected (Quarter 3)	Continue to monitor. Plan to deploy additional staffing resources in anticipation of high volume of annuals in Q4.	12/31/2018	
24	QIC	Case Management	Sloane Petrillo	High ER Utilization	Evaluation and intervention for ongoing review of high ER utilizers	Identify top 10 high ER utilizers for CCN per quarter (all lines of business); Open to case management with focused group of case managers ; Regular meetings to identify causes of high utilization and effective strategies for reduction in inappropriate ER utilization	5% reduction in ER visits among intervention cohort	Cohort 7 members identified and assigned. Current p lot enrollment is 181. Exceed 5% reduction overall.	Continue to monitor for sustained improvement.	12/31/2018	

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25	QIC	Case Management	Sloane Petrillo	Review Of Member Satisfaction With CM Programs	Annual review of member feedback on the case management programs to assure high satisfaction and improved health status	Review annual satisfaction survey results define areas for improvement and implement interventions to improve member experience with CM programs	Satisfaction with Case Management - 88%	Overall Satisfaction with Case Management: 92%	Continue to monitor for sustained improvement.	12/31/2018	
26	QIC	Case Management	Sloane Petrillo	Coordination of CCS Medical Home and CalOptima PCP	Monitor coordination efforts between CCS Medical Home and CalOptima PCP's	Coordinated quarterly review with CCS. Establishment of pilot to address CCS questions. Root cause analysis completed.	90%	Quarter 3 sample yielded a match of 50% between the medical home and CalOptima PCP.	Continue working through pilot. Extensive discussion with CCS regarding barriers to achieving 90% match. Group agrees that Whole Child Model wi l result in 100% match. Planning underway for Whole Ch ld Model which will ensure PCP alignment. Whole Child Model transition date has been moved to 7/1/2019.	12/31/2018	
27	QIC	Case Management	Sloane Petrillo	HN MOC Oversight	Regular review of the Health Network's performance of MOC functions	Review of 100% of MOC files with monthly feedback provided to Health Networks	HN to achieve 80% score on file review monthly	OCC - A l HNs met goal. OC - All HNs met goal. SPD - All HNs met goal.	Continue monitoring of 100% of f les to ensure compliance.	12/31/2018	
	III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH										
28	BHQIC	Behavioral Health	Edwin Poon	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Initiation Phase	Increase chances to meet or exceed HEDIS goals through effective interventions that are a igned with current practice and technological options.	• Continue to hold monthly BH QI work group with representation from the various departments associated with the measures • Continue to work on current intervention focus for AMM and ADD HEDIS measures • BHI has several measures that are being monitored which may also serve as opportunity for improvements	Medicaid Goal Initiation: 48.18% Continuation: 44.80%	AltaMed did not meet goal for one month. CHOC did not meet goal for one month. Regal did not meet goal for one month. Prospect did not meet goal for two months. UCMG did not meet goal for two months.	Offer additional training to lower performing networks. Revise and standardize feedback letters.		
29	BHQIC	Behavioral Health	Edwin Poon	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 a igned with current practice and technological options.	• Continue to hold monthly BH QI work group with representation from the various departments associated with the measures • Continue to work on current intervention focus for AMM and ADD HEDIS measures • BHI has several measures that are being monitored which may also serve as opportunity for improvements	Medicaid Goal Continuation: 44.80% Initiation: 48.18%	**Medicaid Goal** Initiation: 48.18% Continuation: 44.80% **Final Rates** Initiation: 42.07% Continuation: 45.89% P50: 44.80% P50: 55.90%	Q4 Phone call reminders to Top 10-20 Providers and Clinics with first ADD script on file and record of low follow up rates.	Q1 2019 Measurement Year begins and ends in Q1	

#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
30	BHQIC	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM): Acute Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are a igned with current practice and technological options.	• Continue to hold monthly BH QI work group with representation from the various departments associated with the measures • Continue to work on current intervention focus for AMM and ADD HEDIS measures • BHI has several measures that are being monitored which may also serve as opportunity for improvements	Medicaid: 56.94% OneCare: 75.00% OneCare Connect: 63.45%	**Medicaid Goal** Acute: 56.94% **Final Rates** acute: 56.7% P50: 51.89% **MediCare Goal** Acute: 63.45 Final rates: Acute: 62.59% P50: 69.11	Measure covered in BHQI Work group monthly. Rates are not moving but analysis shows they have been stagnate for the past 3 years. Maybe time to shift focus to other new measures and keep monitoring. BHQI work group to decide and present to BHQI for next steps	4Q	
31	BHQIC	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM): Continutation Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are a igned with current practice and technological options.	• Continue to hold monthly BH QI work group with representation from the various departments associated with the measures • Continue to work on current intervention focus for AMM and ADD HEDIS measures • BHI has several measures that are being monitored which may also serve as opportunity for improvements	Medicaid: 41.12% OneCare: 53.90% OneCare Connect: 47.09%	**Medicaid Goal** Continuation: 41.12% **Final Rates** Continuation: 41.12% P50: 36.19%	Measure covered in BHQI Work group monthly. Rates are not moving but analysis shows they have been stagnate for the past 3 years. Maybe time to shift focus to other new measures and keep monitoring. BHQI work group to decide and present to BHQI for next steps	4Q	
32	BHQIC	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 30 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure: - The percentage of discharges for which the patient received fo low up within 30 days of discharge	OCC Quality Withold Goal: 60.89%	**Medicare Goal** 30 days: 60.89% **Final Rates** 46.81% P50: 52.40%	Meeting monthly with Magellan to review list of members in this category and actions taken to follow up visit for care in 30 day period post discharge. Monthly PR rates and member list sent to MBHO for review/analysis and plan of address	4Q	
33	BHQIC	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 7 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure: - The percentage of discharges for which the patient received fo low up within 7 days of discharge	OCC Quality Withold Goal: 56%	**Medicare Goal** 7 days: 56% **Final Rates** 28.72% P50: 31.21%	Meeting monthly with Magellan to review list of members in this category and actions taken to follow up visit for care in 30 day period post discharge Monthly PR rates and member list sent to MBHO for review/analysis and plan of address	4Q	
34	BHQIC	Behavioral Health	Edwin Poon	Interdisciplinary Care Treatment Team Participation	Behavioral health services integration and coordination of care will be monitored and measured	Monitor and identify opportunities to improve integration and coordination of care across settings and /or transitions of care through ICT/ICP	Maintain or improve the participation rate of 95% or higher for Medi-Cal One Care and One Care Connect ICTs or ICPs completed	BH continues to see increase in participation rates of BH providers. Goal of 95% or higher implemented this year in comparison to last years goal of 10% increase over the previous year results. Once adjusted for definition changes in what constitutes Participation the rates have shown an increase between Q2 adn Q3. Q3: 70 % participation rate	BH Clinician targets Medi-Cal Population ICT invitations and participates in weekly ICT meetings to represent BH and invite external partners. MBHO targets OCC population in kind.	4Q	

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35	BHQIC	Behavioral Health	Edwin Poon	Adopt Behavioral Health Clinical Practice Guidelines	BH Clinical Practice Guidelines will be reviewed and adopted	Adoption of at least two behavioral health Clinical practice guidelines will be reviewed and adopted	Annual Adoption of BH Clinical Practice Guide ines	Requirement met for 2 year period. Next review will be conducted in Q1 2019	completed	2Q	
	IV. QUALITY OF CLINICAL CARE - LONG TERM SERVICES AND SUPPORTS										
40	UMC	LTSS	Steven Chang	Operational Performance: CBAS	100 % Compliance	Timeliness of Determination: Inquiry to CEDT completion	CBAS CEDT TAT: 100% completed within 30 calendar days of request for services.	QTR 3 CBAS CEDT: 100%	Continue to monitor	Q4	
41	UMC	LTSS	Steven Chang	Operational Performance	Consistent application of guidelines	Inter-Rater Reliabi ity (IRR) assessment to ensure consistent application of guidelines	Annual IRR assessment will reflect a score ≥ 90% Annual Assessment occurs in Quarter 2	N/A	LTSS Clinical staff will complete IRR testing in May 2019	Q2 2019	
42	UMC	LTSS	Steven Chang	Operational Performance: MSSP	Ensure provision of MSSP to maximal participants (within program constraints).	Monitor: New Admissions Discharges (voluntary terminations and involuntary terminations)	Discharges will not exceed New Admissions by more than two members during the quarter.	QTR 3: New Admissions: 33 Voluntary Terminations: 13 Involuntary Terminations: 18	Continue to monitor	Q4	
43	LTSS-QISC	LTSS	Steven Chang	Number of CBAS members transitioned to LTC.	Promote continued community placement when safe and appropriate.	Track CBAS participants who transition to LTC.	Less than 0.50% of CBAS participants will transition to LTC during the quarter.	QTR 3: Medi-Cal: 6/2351 (0.25%) OCC: 1/165 (0.60%)	Continue to monitor	Q4	
44	UMC	LTSS	Steven Chang	Overall Ratio of average CBAS ut lization (delivered) to average authorization (approved) for CBAS participation days.	Ensure appropriate level (amount) of CBAS services.	Implement processes to track authorized days versus actual participant days. Evaluate variance reasons (e.g. illness hospitalized vacation)	80% of authorized CBAS participation days will be utilized/de ivered.	QTR 3: 97 069 Days Used of 121 123 Authorized (80.14%)	Continue to monitor	Q4	
45	LTSS-QISC	LTSS	Steven Chang	Overall ratio of members participating in CBAS versus potentially program-eligible members.	Promote continued community placement with HCBS when safe and appropriate.	Quarterly reporting	Overall CBAS participation ratio does not decrease from previous quarter.	QTR 3: OCC: 165/14 817 (1.11%) = Increase Medi-Cal: 2 348/37 502 (6.26%) = Decrease	Continue to monitor	Q4	
46	LTSS-QISC	LTSS	Steven Chang/Laura Guest	Member satisfaction	Evaluate member satisfaction with LTSS programs.	Annual member satisfaction survey: CBAS and LTC	Average CBAS Member Satisfaction will exceed 85%. Average LTC Member Satisfaction will exceed 65%.	N/A	2018 survey in progress	Q4	
47	LTSS-QISC	LTSS	Steven Chang	Overall ratio of members residing in LTC versus entire OCC/SPD memberships.	Monitor impact of HCBS in promoting residence in least restrictive environment.	Quarterly reporting	Overall LTC residency ratio does not increase from previous quarter.	QTR 3: OCC: 231/14 817 (1.56%) = Decrease SPD: 4 966/37 502 (13.24%) = Increase	Continue to monitor	Q4	
48	LTSS-QISC	LTSS	Steven Chang	Number of LTC members successfully transitioned out to a lower LOC/community.	Monitor impact of focused transition efforts supporting member transitions to the community.	Quarterly reporting	Percentage of LTC members successfully transitioned to lower LOC/community does not decrease from previous quarter.	QTR 3: 51 of 5 197 members (1.00%)	Continue to monitor	Q4	
49	LTSS-QISC	LTSS	Steven Chang	MSSP Transition Planning	Coordinated transition of all MSSP members into new benefit model.	Transition planning involving DHCS CDA internal and external stakeholders.	1/1/2020 is scheduled transition date.	Meetings with internal stakeholders held.	Conitnue communication and coordination with DHCS and CDA.	Q1 2020	
	V. QUALITY OF CLINICAL CARE - HEDIS										

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#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
52	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Testing	Outreach to members who are due for HbA1c testing. Interventions may include; targeted mailings educational outreach by health coaches/educators and incentives.	Medicaid: 87.1% OneCare: 93.82% OneCare Connect: 91.73%	**HEDIS 2018 Final Rates:** Medicaid: 90.75%; **Met Goal** OneCare: 90.32%; Goal not met OneCare Connect: 90.05%; Goal not met **Sept 2018 Prospective Rates:** Medicaid: 80.5% OneCare: 81.27% OneCare Connect: 83.04% - All LOBs are performing better when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices 2) DM: Member incentive programs to be implemented Q2 2018 3) targeted mailings 4) educational outreach by health coaches/ educators.	4Q	
53	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)	Outreach to members who have poor or uncontro led HbA1c levels. For the CCN population targeted outreach to high volume providers via medical director outreach. Interventions may include; targeted mai ings educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 29.07% OneCare: 20% OneCare Connect: 27%	**HEDIS 2018 Final Rates:** Medicaid: 22.87%; **Met Goal** OneCare: 18.95%; **Met Goal** OneCare Connect: 21.94%; **Met Goal** **A lower rate is better for this measure.** **Sept 2018 Prospective Rates:** Medicaid: 59.48% OneCare: 72.28 % OneCare Connect: 71.67% - MC and OCC are performing lower when compared to same time last year. Whereas OC is performing better than same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices 2) DM: Member incentive programs to be implemented Q2 2018 3) targeted mailings 4) educational outreach by health coaches/ educators.	4Q	
54	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Control (<8.0%)	Interventions may include; targeted mailings with educational materials. Members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 59.12% OneCare: 69.71% OneCare Connect: 64.72%	**HEDIS 2018 Final Rates:** Medicaid: 63.99%; **Met Goal** OneCare: 76.61%; **Met Goal** OneCare Connect: 70.15%; **Met Goal** **Sept 2018 Prospective Rates:** Medicaid: 34.28% OneCare: 22.85% OneCare Connect: 24.42% - MC rates is performing lower compared to same time last year. OC/OCC rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices 2) DM: Member incentive programs to be implemented Q2 2018 3) targeted mailings 4) educational outreach by health coaches/educators.	4Q	
55	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Eye Exam	Targeted outreach to members who are due for a diabetic eye exam. Interventions may include; targeted mailings educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 65.83% OneCare: 81% OneCare Connect: 81%	**HEDIS 2018 Final Rates:** Medicaid: 65.94%; **Met Goal** OneCare: 76.61%; Goal not met OneCare Connect: 77.55%; Goal not met **Sept 2018 Prospective Rates:** Medicaid: 49.23% OneCare: 55.43% OneCare Connect: 62.04% - MC and OCC rates are performing better when compared to same time last year. Whereas OC rates are performing lower at the same time.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices 2) DM: Member incentive programs to be implemented Q2 2018 3) targeted mailings 4) educational outreach by health coaches/educators.	4Q	
56	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Medical Attention for Nephrology	Targeted outreach to members who are due for a screening. Interventions may include; targeted mai ings educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 91.24% OneCare: 94% OneCare Connect: 96%	**HEDIS 2018 Final Rates:** Medicaid: 91.73%; **Met Goal** OneCare: 89.52%; Goal not met OneCare Connect: 95.15%; Goal not met **Sept 2018 Prospective Rates:** Medicaid: 88.12% OneCare: 88.76% OneCare Connect: 93.16% All LOBs are performing better when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices 2) targeted mailings 3) educational outreach by health coaches/educators.	4Q	

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57	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg	Outreach to diabetic members with high blood pressure. Interventions may include; targeted mai ings educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 72.24% OneCare: 80.12 OneCare Connect: 70.83%	**HEDIS 2018 Final Rates:** Medicaid: 72.26%; **Met Goal** OneCare: 79.03%; Goal not met by <1% OneCare Connect: 69.90%; Goal not met <1% **Sept 2018 Prospective Rates:** Medicaid: 20.53% OneCare: 37.08% OneCare Connect: 29.61% All LOB rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices 2) DM: Member incentive programs to be implemented Q2 2018 3) targeted mailings 4) educational outreach by health coaches/educators.	4Q	
58	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	All-Cause Hospital Readmissions (PRC)	Continue to implement the Transition of Care program; focus on the health coaching intervention.	OneCare: 6% OneCare Connect: 9%	**HEDIS 2018 Final Rates:** OneCare: OneCare Connect **Sept 2018 Prospective Rates:** OneCare: 16.28% OneCare Connect: 11.89 % - OC rates are lower and OCC rates are better when compared to last year and close to the goal of 9%.	Continue to implement the Transition of Care program; focus on the health coaching intervention. Working on improving data process and va idating results on a monthly basis	4Q	
59	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July 2018.	Medicaid: 86.79%	**HEDIS 2018 Final Rate:** Medicaid: 86.16%; Goal not met by <1% **Sept 2018 Prospective Rates:** Medicaid: 74.55% - Prenatal rate is slightly lower when compared to same time last year.	Continue with targeted prenatal and postpartum mailings until the launch of the Bright Steps program. Implement the member incentive program in June 2018.	4Q	
60	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC): Postpartum Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July 2018.	Medicaid: 69.44%	**HEDIS 2018 Final Rate:** Medicaid: 71.75%; **Met Goal** **Sept 2018 Prospective Rates:** Medicaid: 49.65 % - Postpartum rate is higher when compared to same time last year.	Continue with targeted prenatal and postpartum mailings until the launch of the Bright Steps program. Member incentive program launched in Q2. [Runs from June 1-Dec. 31 2018]	4Q	
61	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS): Combo 3	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events target mailings incentives and facets pop-ups.	Medicaid: 74.39%	**HEDIS 2018 Final Rate:** Medicaid: 74.94%; **Met Goal** **Sept 2018 Prospective Rates:** Medicaid: 51.49% - Rate is higher when compared to same time last year.	Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3 2018. These events will impact the following measures [CIS IMA WC15 W34 AWC]	4Q	
62	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS): Combo 10	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events target mailings incentives and facets pop-ups.	Medicaid: 37.23%	**HEDIS 2018 Final Rate:** Medicaid: 45.01%; **Met Goal** **Sept 2018 Prospective Rates:** Medicaid: 29.61% - Rate is higher when compared to same time last year.	Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3 2018. These events will impact the following measures [CIS IMA WC15 W34 AWC]	4Q	

#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
63	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Lower Back Pain (LBP)	Provider education and outreach	Medicaid: 74.40%	**HEDIS 2018 Final Rate:** Medicaid: 70.50%; Goal not met **Sept 2018 Prospective Rates:** Medicaid: 70.97% - Rate is higher when compared to same time last year. Measure currently at the 50th percentile.	Developing a news article for Provider Update and/or targeted mailings to Providers.	4Q	
64	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events target mailings incentives and facets pop-ups.	Medicaid: 76.17%	**HEDIS 2018 Final Rate:** Medicaid: 68.65%; Goal not met **Sept 2018 Prospective Rates:** Medicaid: 61.73 % - Rate is higher when compared to same time last year	Implement PIP activities focusing on targeted provider offices. Develop/Update educational materials for members to be included in newsletters.	4Q	
65	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 12-24 months	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events target mailings incentives and facets pop-ups.	Medicaid: 95.7%	**HEDIS 2018 Final Rate:** Medicaid: 93.44%; Goal not met by 2.26% **Sept 2018 Prospective Rates:** Medicaid: 91.73% - Rate is lower when compared to same time last year.	Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3 2018. These events will impact the following measures [CIS IMA WC15 W34 AWC]. Close to reaching goals for all submeasures. Activities are in progress.	4Q	
66	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 25 months - 6 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events target mailings incentives and facets pop-ups.	Medicaid: 87.87%	**HEDIS 2018 Final Rate:** Medicaid: 87.63%; Goal not met by <1% **Sept 2018 Prospective Rates:** Medicaid: 73.70% - Rate is lower when compared to same time last year	Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3 2018. These events will impact the following measures [CIS IMA WC15 W34 AWC]. Close to reaching goals for all submeasures. Activities are in progress.	4Q	
67	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 7-11 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events target mailings incentives and facets pop-ups.	Medicaid: 90.77%	**HEDIS 2018 Final Rate:** Medicaid: 90.67%; Goal not met by <1% **Sept 2018 Prospective Rates:** Medicaid: 87.78% - Rate is lower when compared to same time last year	Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3 2018. These events will impact the following measures [CIS IMA WC15 W34 AWC]. Tdap targets members 10-13 years olds which impact CAP population. Close to reaching goals for all submeasures. Activities are in progress.	4Q	

#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
68	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 12-19 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events target mailings incentives and facets pop-ups.	Medicaid: 89.52%	**HEDIS 2018 Final Rate:** Medicaid: 87.32%; Goal not met 2.2% **Sept 2018 Prospective Rates:** Medicaid: 84.66% - Rate is lower when compared to same time last year	Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3 2018. These events will impact the following measures [CIS IMA WC15 W34 AWC]. Events also impacts the CAP population. Close to reaching goals for all submeasures. Activities are in progress.	4Q	
69	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Cervical Cancer Screening (CCS)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screening events target mailings incentives and facets pop-ups.	Medicaid: 58.48%	**HEDIS 2018 Final Rate:** Medicaid: 60.24%; **Met Goal** **Sept 2018 Prospective Rates:** Medicaid: 53.31% - Rate is higher when compared to same time last year	Implement the member incentive program in June 2018. Plan targeted mailings.	4Q	
70	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Child Visits in the 3rd 4th 5th and 6th Years of Life (W34)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites target mailings incentives and facets pop-ups.	Medicaid: 80.64%	**HEDIS 2018 Final Rate:** Medicaid: 83.15%; **Met Goal** **June 2018 Prospective Rates:** Medicaid: 48.02% - Rate is lower when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS IMA WC15 W34 AWC]	4Q	
71	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Care Visits in first 15 months of life (W15)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites target mailings incentives and facets pop-ups.	Medicaid: 56.11%	**HEDIS 2018 Final Rate:** Medicaid: 48.18%; Goal not met **Sept 2018 Prospective Rates:** Medicaid: 27.35% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS IMA WC15 W34 AWC]	4Q	
72	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Appropriate Testing for Children with Pharyngitis (CWP)	Provider outreach at PCP sites Target urgent care centers	Medicaid: 67.15%	**HEDIS 2018 Final Rate:** Medicaid: 55.37%; Goal not met **Sept 2018 Prospective Rates:** Medicaid: 56.94% - Rate is higher when compared to same time last year	Focus is on Urgent Care centers. Purchasing kits to distribute to CCN contracted Urgent Care centers and some targeted high-volume offices.	2Q2019	
73	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Colorectal Cancer Screening (COL)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screenings event target mailings incentives and facets pop-ups.	OneCare: 63% OneCare Connect: 63%	**HEDIS 2018 Final Rates:** OneCare:63.07%; **Met Goal** OneCare Connect: 61.99%; Goal not met **Sept 2018 Prospective Rates:** OneCare: 52.03 % OneCare Connect: 48.04% - OC and OCC rates are better when compared to same time last year.	Add article in OCC newsletter and/or send targeted mailing to OC and OCC members in Q4.	4Q	
74	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Medication Review	Targeted outreach to providers; obtain ICP for each members	OneCare: 88% OneCare Connect: 79%	**HEDIS 2018 Final Rates:** OneCare: 90.13%; **Met Goal** OneCare Connect: 79.81%; **Met Goal** **Sept 2018 Prospective Rates:** OneCare: 34.78% OneCare Connect: 28.54% - OC and OCC rates are better when compared to same time last year.	Case Management to continue outreaching and obtaining ICPs. CM updated the HRA form and collect information at first contact with members. Implement OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).	4Q	

#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
75	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Functional Status Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare: 67% OneCare Connect: 67%	**HEDIS 2018 Final Rates:** OneCare: 73.68%; **Met Goal** OneCare Connect: 59.37%; Goal not met **Sept 2018 Prospective Rates:** OneCare: 33.54% OneCare Connect: 29.18 % - OC and OCC rates are better when compared to same time last year.	Case Management to continue outreaching and obtaining ICPs. CM updated the HRA form and collect information at first contact with members. Implement OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).	4Q	
76	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Pain Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare: 94% OneCare Connect: 80%	**HEDIS 2018 Final Rates:** OneCare: 88.16%; Goal not met OneCare Connect: 75.67%; Goal not met **Sept 2018 Prospective Rates:** OneCare: 35.40% OneCare Connect: 29.61% - OC and OCC rates are better when compared to same time last year.	Case Management to continue outreaching and obtaining ICPs. CM updated the HRA form and collect information at first contact with members. Implement OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).	4Q	
77	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Breast Cancer Screening (BCS)	Targeted outreach to members who are due for a screening. Interventions may include; mobile mammography event target mailings incentives and facets pop-ups.	Medicaid: 65.52% OneCare: 78% OneCare Connect: 78%	**HEDIS 2018 Final Rates:** Medicaid: 63.73%; Goal not met OneCare: 66.13%; Goal not met OneCare Connect: 66.93%; Goal not met **Sept 2018 Prospective Rates:** Medicaid: 56.52% OneCare: 65.85% OneCare Connect: 58.64 % - All LOB rates are lower when compared to same time last year.	Implement the Medi-Cal member incentive program in June 2018. Caloptima to collaborate with community clinics to host mobile mammography screening events for CCN members. CalOptima is contracted with A inea (mobile mammography vendor) to provide direct services to CCN members.	4Q	
78	QIC	Qua ity Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Avoidance of Ant biotic Treatment in Adults with Acute Bronchitis (AAB)	Provider education via the AWARE Toolkit.	Medicaid: 24.91%	**HEDIS 2018 Final Rate:** Medicaid: 25.05%; **Met Goal** **Sept 2018 Prospective Rates:** Medicaid: 26.64% - Rates are better when compared to same time last year.	Send AWARE toolkit in Q4 2018.	4Q	
79	QIC	Pharmacy	Nicki Ghazanfarpour Pharm.D./Kris Gericke	Improve identified HEDIS Measures	Statin Therapy for Patients with Cardiovascular Disease (SPC)	Physician not fication faxes	MCAL Statin therapy: 75.85% OCC Statin therapy: 73.56 Adherence: 71.14% OC Denominator too small last year to set goal	MCAL: faxes sent to 289 providers for 770 members OCC: faxes sent to 124 providers for 68 members OC: faxes sent to 10 providers for 12 members Failed faxes: 5 failed fax for 5 prescriber (22 members) Barriers: -HEDIS registry data refreshes in January so intervention data has to be tweaked to take into account end of the year pharmacy claims for statins (more manual) -Bad/Missing data: Incorrect fax numbers oudated provider locations PCPs not assigned -True prospective rates for adherence submeasure not readily ava lable until close of look of year Members removed from intervention due to: -Loss of eligib lity Provider responses prompting removal from intervention faxes: -Member can not tolerate a moderate/high potency statin or all statins -Member has allergy to statins -Contraindications for taking a statin Enhancements: -Adherence calculation using Proportion of Days Covered (PDC) automated in 3Q18 with a 12 month look back. This real-time rate will be used to flag and target members who are on a statin but remain non-adherent (<80% PDC). Adherence percentage provided to PCPs in the faxes for non-adherent members. 2017 Final HEDIS rates: MCAL: Statin therapy: 73.64%; Adherence: 71.91% OCC: Statin therapy: 70.45%; Adherence: 70.41% OC: Statin therapy: 45.45%; Adherence: 100%	4Q18 faxes	4Q	

#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
80	QIC	Pharmacy	Nicki Ghazanfarpour Pharm.D./Kris Gericke	Improve identified HEDIS Measures	Statin Therapy for Patients with Diabetes (SPD)	Physician not fication faxes	MCAL Statin therapy: 66.31% Adherence: 67.76% (5/2/18- OC/OCC was added to goal/Time ine) OCC Statin therapy: 73.83% Adherence: 74.75% OC Statin therapy: 67.37% Adherence: 77.13%	MCAL faxes sent to 591 p ov de s fo 8447 membe s OCC faxes sent to 383 p ov de s fo 910 membe s OC faxes sent to 54 p ov de s fo 70 membe s Fa led faxes 14 fa led faxes fo 14 un que p esc be s 168 membe s (ac oss all LOBs) Ba e s -HED S eg st y data ef eshes n Janua y, so nte vent on data has to be tweaked to take nto account end of the yea pha macy cla ms fo stat ns (mo e manua) -Bad/M ss ng data Inco ect fax numbe s, oudated p ov de locat ons, PCPs not ass gned -T ue p ospect ve ates fo adhe ence submeasu e not ead ly ava lable unt l close of look of yea Membe s emoved f om nte vent on due to -Loss of el g b l ty P ov de esponses p ompt ng membe emoval f om nte vent on -Membe does not have d abetes -Membe efuses to take stat n Enhancements -Adhe ence calculat on us ng P opo t on of Days Cove ed (PDC) automated n 3Q18 w th a 12 month look back. Th s eal-t me ate w l be used to flag and ta get membe s who a e on a stat n, but ema n non-adhe ent (80% PDC). Adhe ence pe centage p ov ded to PCPs n the faxes fo non-adhe ent membe s. 2017 F nal HEDIS ates MCAL Stat n the apy 65.44% Adhe ence 65.28% OCC Stat n the apy 73 25% Adhe ence 71.98% OC Stat n the apy 66.18% Adhe ence 76.67% Rates th ough August 2018	4Q18 faxes	4Q	
81	QIC	Pharmacy	Nicki Ghazanfarpour Pharm.D./Kris Gericke	Improve identified HEDIS Measures	Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	Physician not fication faxes	MCAL: 80.95% (5/2/18- OC/OCC was added to goal/Time ine) OCC: 96.1% OC: Denominator too small last year to set goal	MCAL: faxes sent to 24 providers for 28 members OCC: faxes sent to 5 providers for 5 members OC: none Failed faxes: none Barriers: -HEDIS registry data refreshes in January so intervention data has to be tweaked to take into account end of the year pharmacy claims for beta blockers -Failed faxes require manual intervention Members removed from intervention due to: -Loss of eligib lity October 2018 Prospective Rates MCAL: 77.14% (above 25th percent le) OCC: 80% (below 25th percentile) --> October 2017: 66.07% OC: 100% 2017 Final HEDIS rates: MCAL: 79.79% (goal 83.06%); below 50th percent le OCC: 96.97% (goal NA); above 75th percentile OC: NA (denominator too small to report)	4Q18 faxes	4Q	
	VI. QUALITY OF CLINICAL CARE - HEALTH EDUCATION & DISEASE MANAGEMENT										
82	QIC	HE & DM	Pshyra Jones	Initial Health Assessment Completion Rate	To assure all new members are connected with a PCP and their health risks are assessed	IHA/IHEBA [Staying Healthy Assessment(SHA)] w ll be completed within 120 days of enrollment; Reports will be available for Health Networks on IHA/SHA completion; Facility Site Reviews wi l review a sample of medical records for comp iance with completing appropriate age level IHA/SHA; If use of alcohol or drugs the member will have an SBIRT documented (Screening Brief Intervention and Referral to Treatment)	Improve plan performance over 2017 by 5%	**Updates to Methodology (August 2018)** 1. Remove hosp tal and u gent ca e cla ms whe e IHADueDate s g eate than o equal to 01/01/2018. 2. Update the Ut l zat on_Met f om 120 to 119 and Ut l zat on_Met60Days f om 60 to 59 to match the IHADueDate log c. 3. Added p ocedu e codes G0443 and G0442 s nce these two codes eplaced H0049 and H0050 codes. **IHA Completion Rates*** Q1 2018 - 43.54% Q2 2018 - 40.19% Q3 2018 - 39.46% *Data as of 10/15/18 HA pe fo mance calculated as fully met pa t ally met (Fully Met=Ev dence of an IHA v s t and SHA w th n 120 days of membe effect ve date Pa t ally Met=Ev dence of an IHA v s t o SHA w th n 120 days of membe effect ve date) **IHA Chart Audit Results** A cha t aud t was completed at CalOpt ma's commun ty cl n cs to assess IHA cha t compl ance and gaps n cha t documentat on by HA component. Pe centages n pa antheses demonst ate an nc ease o dec ease compa ed to 2017. IHA Cha t Compl ance - 45 03% (↑ 6.34%) **Gaps n Chart Documentation** Comp ehens ve H sto y - 77.72% (↓ 6.2%) P event ve Se v ces - 90.22% (↑ 1 59%) Comp ehens ve Phys cal/Mental Status Exam - 87.66% (↑ 9.59%) D agnoses and Plan of Ca e - 98.08% (↑ 3.89%) SHA - 60 90% (↑12.81%)	Present IHA Chart Audit Results to Clinics	12/31/2018	

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83	QIC	HE & DM	Pshyra Jones	Review of Disease Management Programs	Disease Management activity reviewed to assess clinical care delivered to members with Asthma Diabetes and Heart Failure	Develop DM Program interventions to help improve HEDIS measures such as AMR MMA MPM CBP; Assure DM programs are implemented across all populations; Conduct annual member satisfaction of DM programs; Evaluate the overall effectiveness of the Program-Participation Member Rates ED IP and RX related utilization	Improve program participation rates over 2017 by 3% Reduce ED and IP rates for program participants by 3% Increase member satisfaction with DM Programs to 90%	**September 20 8 Medi-Cal Prospective Rates:** AMR 5-11: 69.92% ↓ 6.38% since June - 25th percentile MMA 5-64: 57.53% ↑57.31% since June - Above 90th percentile HbA1c Testing: 80.50% ↑ 11.55% since June - below 25th percentile HbA1c Poor Control: 59.48% ↑0.33% since June - decrease is better - below 25th percentile Eye Exam: 49.23% ↑7.99% since June - 25th percentile Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBs: 81.08% - ↑ 10.7% since June -below 25th percentile 2017 DM Satisfaction -98.4% actively managed DM members are overall satisfied with CalOptima's DM Programs **September 20 8 OC Prospective Rates:** HbA1c Testing 81.27% ↑11.42% since June 2018 - below 25th percentile HbA1c Poor Control: 72.28% ↓0.88% since June - decrease is better - below 25th percentile Eye Exam: 55.43% ↑8.37% since June - below 25th percentile Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBs: 85.25% - ↑ 12.81% since June -below 25th percentile **September 20 8 OCC Prospective Rates**: HbA1c Testing:83.04% ↑ 10.41% since June 2018 - below 25th percentile HbA1c Poor Control: 71.67% ↑0.12% since June - decrease is better - below 25th percentile Eye Exam: 62.04% ↑8.89% since June - below 25th percentile Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBs: 84.56% - ↑ 11.85% since June -below 25th percentile	*Identified programming issues with Diabetes methodology. Revised identification criteria is scheduled for December or January implementation in Guiding Care. *Continue efforts with Alturista Health to improve member triage and referral to staff (Round Robin) * Continue the targeted campaigns for AMR through Asthma Action Plan and member incentive for Diabetes eye exam and A1C testing.	12/31/2018	
84	QIC	HE & DM	Pshyra Jones	Implementation of Population Health & Wellness Programs	Expand child and adolescent components for the Shape Your Life/Weight Management Program; Implement Weight Watchers benefit for Shape Your Life CalOptima Medi-Cal members age 15 years or greater; Design and implement a comprehensive Perinatal Health Program	Establish program goals objectives and interventions; Develop clinical and operational components to expand the reach and capability; Identify program resources and vendor support (Provider Health Ed/RD linkages Community Based Organizations); Implementation of revised program design	Implement revised program design-2018; Evaluate progress semi-annually	SYL vendor contracts effective on 4/1/18 to implement a group class model. Perinatal Health program is being branded as *Bright Steps.* Board approval (July 2018) to cancel RFP (Dec 2017) and allow for contracting with any qualified CPSP or PSS provider for eligible services at 100% MC rate.	Continued implementation of Bright Steps program Complete 6 month evaluation of SYL program and present at QAC	1Q 2019	
85	QIC	HE & DM	Pshyra Jones	Adopt Medical Clinical Practice Guide ines	Clinical Practice Guidelines will be reviewed and adopted	Adoption of Clinical Practice Guidelines as least three (3) will be reviewed and adopted (linked to DM: Diabetes Asthma CHF)	CPG's reviewed and adopted every two years	CPGS approved in July 2017	Next review in 2019	Q2019	
	VII. QUALITY OF CLINICAL CARE - QUALITY IMPROVEMENT PROJECTS										
86	QIC	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP PIPS CCIPs PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs) PDSAs CCIPs	**OneCare CCIP:** Diabetes to improve HBA1C Testing Targeted mailings to members; Outreach to health networks; provide monthly Prospective Rates and member deta l information to health networks	Goal TBD/ Starting January 2018	Health Coach ca l interventions completed first round for OneCare CCIP diabetes HBA1C testing.	Health coach interventions to continue in 4th Quarter	12/31/2018	
87	QIC	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP PIPS CCIPs PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs) PDSAs CCIPs	OneCare Connect CCIP: Heart Health	Goal TBD/ Starting January 2018	Program began in September for pilot of CCN identified CHF members with admission; once identification reporting issues resolved process and responsibilities finalized between DM and Pharmacy. Health Coach contacts have been initiated within 1 week of identification.	Health coach interventions to continue in 4th Quarter	12/31/2018	
88	QIC	Qua ity Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP PIPS CCIPs PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs) PDSAs CCIPs	OneCare Connect QIP: To Improve 30-day Readmission Rate <16.8% ; Transition of Care program; health coach outreach	OneCare Connect QIP: To Improve 30-day Readmission Rate <16.8%; Transition of Care program; health coach outreach	OCC August PR Rate: 11.35%	Continue to implement the Transition of Care program; focus on the health coaching intervention at the two (2) targeted hospitals. Team will also continue efforts to improve data process and validating results on a monthly basis. There has been rate improvements since the last update. QIP is on track.	4Q	

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89	QIC	Qua ity Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP PIPS CCIPs PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs) PDSAs CCIPs	**OneCare QIP (NEW)**: Improving hypertension management and caregiver involvement in the OC SNP population	**QIP Goals:** 1) Obtain 30% PHI forms for OC hypertension members w/ outdated caregiver information. 2) Reach a 10% opt-in participation rate of eligible OC hypertension members or caregivers to provide telephonic coaching. 3) Demonstrate decrease in blood pressure values of 20% of active participants in the coaching program over member's personal baseline.	Disease Management mailed OneCare members with hypertension information about engaging their caregivers and providing support. PHI forms were included in this mailing so that CalOptima could share information with caregivers to improve delivery of services. This mailing was sent to 329 members in October 2019. This is an OPT-IN program only. 10/08/18: CMS notified CalOptima that QIPs are no longer a requirement for the OneCare population in moving forward and we will be closing out this OC QIP at the end of 20 8.	Disease Management dropped mailing to 329 OneCare members.	4Q	
90	QIC	Qua ity Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP PIPS CCIPs PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs) PDSAs CCIPs	**Medi-Cal PIP:** Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c >9%) residing in Santa Ana CA. (Focus on health disparities); Targeted provider outreach in the CCN network; Increase referrals and participation in CalOptima' Disease Management program; Educational classes	**PIP**: Reduce the Poor Control (HbA1c >9) targeted group down from 62.5% to 52.31%	Module 4 Plan was approved by HSAG. Intervention implementation started Sept 2018: Health Coaches conducted targeted outreach to members to provide comprehensive telephonic counseling services.	Submitted Module 3 of the PIP on 5/15/18 to DHCS for approval. On Track **Proposed Interventions:** 1) Conduct targeted outreach by a health coach to provide comprehensive telephonic counseling services. 2) Provide member registry list to targeted provider offices for outreach.	2Q2019	
91	QIC	Qua ity Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP PIPS CCIPs PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs) PDSAs CCIPs	**Medi-Cal PIP:** Improving Adult's Access to Preventive/Ambulatory Health Services: Ages 45-64 years	Improving Adult's Access to Preventive/Ambulatory Health Services: Ages 45-64 years PIP Goal: 82.49%	Module 4 (Plan Section) approved by HSAG: Intervention: In process. Conducting outreach to targeted provider offices in Q4. Planned intervention: 1) Office staff at the targeted provider offices are to conduct targeted outreach to schedule preventive/well-care visits for members. Office staff are incentivized based on improvement. 2) Members are incentivized to complete a preventive/well-care visit with their PCP and can receive a $25 g ft card.	Submitted Module 3 of the PIP on 5/15/18 to DHCS for approval. On Track. **Proposed Interventions:** 1) Office staff to conducted targeted outreach to schedule preventive/well-care visits 2) Test holding extended office hours beyond normal provider office hours of operations with targeted offices.	2Q2019	
92	QIC	Qua ity Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP PIPS CCIPs PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs) PDSAs CCIPs	**OneCare Connect PIP:** Improving rate of completed Individualized Care Plan Completed for members and improve rate of Members with Documented Discussions of Care Goals	PIP: Member with an Individua ized Care Plan Completed/Members with Documented Discussions of Care Goals (OCC) 1) CA 1.5 – Members with an Individua ized Care Plan Completed. Year 1 Goal: High Risk: 79.9%; Low Risk: 71% 2) CA 1.6 – Members with Documented Discussions of Care Goals. Year 1 Goal: 77.91%	9/30/18: 1) CA 1.5 – Members with an Individualized Care Plan Completed. **High Risk Rate**: 79.89% Low Risk: 79.89% 2) CA 1.6 – Members with Documented Discussions of Care Goals. **Rate:** 79.18%	To submit PDSA intervention plan due on 7/18/18. Intervention 1 was implemented on 1/3/18. Intervention 2: Implemented 4/3/18. Data collection in process. On Track	12/31/2019	

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93	QIC	Qua ity Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP PIPS CCIPs PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs) PDSAs CCIPs	**OneCare Connect PDSA -** Reducing Avoidable Hospita izations and Other Adverse Events for Nursing Facility Residents (LTC - OCC); Treatment in Place training to targeted facility sites and Follow up with targeted facility sites by CalOptima nurses	**SMART Objective 1** By 6/30/2018, Ca Opt ma w ll offe enhanced ca e coo d nat on to a l OCC CCN LTC membe s w th ≥ two (2) acute adm ss ons w th n the last oll ng 12 months. **SMART Objective 2** By 9/30/2018, the o l ng 12-month ave age acute adm ss ons ep esented by OCC CCN LTC membe s w th mult ple adm ss ons, 2.76 adm ss ons pe membe pe yea at 2017 basel ne, w ll dec ease to ≤2 45 adm ss ons pe membe pe yea **SMART Objective 3** By 3/31/2019, the ove all oll ng 12-month ave age at o of acute adm ss ons ep esented by all OCC CCN LTC membe s, 0.88 adm ss ons pe membe at 2017 basel ne, w ll dec ease to ≤0.79 adm ss ons pe membe pe yea .	Implement enhanced care management strategies in Q2 2018. Data collection in process.	Implement enhanced care management strategies in Q2 2018 CYCLE 1. On Track	Ongoing; PDSA cycles are determined by CMS	
	VIII. SAFETY OF CLINICAL CARE										
94	UMC	Pharmacy	Kris Gericke	Ut lization of Opiod Analgesics	Promote optimal uti ization of opioid analgesics	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics. Prescriber monitoring and education	Reduction in opioid analgesic overutilization as measured by number of prescriptions and quantity per prescription for short-acting opioid analgesics	The average number of Rxs PMPQ for opioid analgesics decreased from 0.0239 to 0.0236 from 2Q18 to 3Q18 (1.3% decrease). The average quantity per Rx for short-acting opioid analgesics decreased from 55.0 to 53.9 from 2Q18 to 3Q18 (2.0% decrease).	Implement additional formulary quantity limits per P&T Committee approval. Continue with quarterly prescriber report cards.	4Q	
95	UMC	Pharmacy	Kris Gericke	Pharmacy Benefit Manager (PBM) Oversight	Provide ongoing monitoring of the PBM contract performance guarantees	Review and report on clinical and service metrics for MedImpact as it relates to performance guarantees	PBM Performance Guarantees met per the PBM Services Agreement	2Q18 Performance Guarantees met.	Continue to monitor quarterly reports.	4Q	
97	CPRC	Qua ity Improvement	Esther Okajima/ Katy Noyes	Providers Shall Have Timely And Complete Facility Site Reviews	To assure all new and re-credentialed providers are compliant with FSR/MRR/PAR requirements	Facility Site Reviews (FSR) Medical Record Reviews (MRR) and Physical Accessibility Review Surveys (PARS) are completed as part of initial and re-credentialing cycles; Report of FSR/MRR/PARS activity to CPRC	100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes measured as 100% Full Scope Periodic Audits completed within three years from the last FSR/MRR and PARS.	In Q3 the FSR/MRR team completed 57 full scope and 19 initial FSR/MRR reviews. Also The PARS team completed 155 PARS but only 41% recevied a BASIC status. This is a trend that the team is seeing over the last few months of 2018. Only 4 Fu l/Scope reviews were overdue which was a significan improvement over previous quarters mainly due to adequate staff since the middle of this year.	Continue to look at opportunities to impact adult preventative measures by having nurses participate in workgroups related to impacted measures. Also communicate to HN areas that fall below the minimum score of 80%	Monitor through Q4	
98	CPRC	Qua ity Improvement	Esther Okajima/ Laura Guest	Follow-up on Potential Quality Of Care Complaints	To assure patient safety and enhance patient experience by timeliness of clinical care reviews	QI Nurse Specialists and Medical Directors review cases and provide determination; Report all case results to CPRC for discussion; Present cases that have a severity rating of 1 (one) or higher wi l be presented to CPRC for action; Follow through on Medical Director determination when applicable to ensure closure and compliance of all cases; Conduct a PQI trend analysis at least two times a year. Review GARS and PQI's twice annually for trends by practitioner.	a)Achieve a turnaround time of 90 days on 90% of cases received. B)Review data for trends and patterns by practitioner. Take appropriate actions for outliers.	a) In Q3 we closed 285 cases as compared to 390 cases in Q2. Of the closed cases 65% of the cases were closed in 90 days or less which is an improvement from Q2 of 56%. b) In September 2018 trending data of practitioners with the highest number of greivances and/or PQIs was presented. The greivances were reviewed for 2 years; PQIs for 3 years. Thirty-four practitioners were identified and 5 were eliminated for a variety of reasons. The remaining physicians all received a letter with their individual rates as compared to others of their specialty. The physicians were provided information and encouraged to have a one-on-one physician coaching session as well as training for their staff. c)We have recategorized the complaint types in Q3. The top 5 PQI complaint types in Q3 were as follows: 1. Medical Care - 161 2.Authorization Issue - 48 3. Medication Issue - 28 4. Communication Issue - 26 5. Access - 16	a) Continue to monitor TAT of cases and identify reasons for not being able to meet the goal. b) Perform trending for the July-Dec 2018 in February 2019. c) Continue to monitor trends of complaint types.	January 31 2019	

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99	LTSS-QISC	Qua ity Improvement	Esther Okajima/ Laura Guest	CBAS Quality Monitoring	Review CBAS quality monitoring of services provided	a) Continue to assess compliance of contracted CBAS Centers. Report to LTSS QIS Subcommittee. b) Continue to review Incident and Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted CBAS centers will be audited at least annually against the audit performed by CDA. b) All (100%) CAPs generated as a result of the audit will be returned by the due date. c) The number of CBAS centers receiving a CAP will be reduced to 75% in 2018 down from 93% in 2017. d) All (100%) Incident and Critical Incident reports will be reviewed for Potential Quality of Care issues	In Q3 9 centers reviewed against CDA audit. Alll 9 centers received a CAP. Three of the Centers have returned the CAP; 6 pending due in November. Incidents and Critical Incidents in Q3: There were no critical incidents reported. Forty-eight incidents were reported. The type of incidents are as follows: 10 falls 10 falls resulted in minor injury 2 falls resulted in transport to hospital 4 diagnosis related incidents required transportation to hospital. Incidents by Facility: Alzheimer's CBAS submitted 9 incident reports. Rio Orange submitted 15 incident reports. 1 incident from Helping Hands resulted in PQI which was resolved.	Continue to provide quality oversight monitoring of the CBAS Centers and review critical incident reports for PQI.	Q4 2018	
100	LTSS-QISC	Qua ity Improvement	Esther Okajima/ Laura Guest	SNF/LTC Quality Monitoring	Review SNF/LTC quality monitoring of services provided	a) Continue to assess compliance of contracted SNF/LTC Faci ities. Report to LTSS QIS Subcommittee. b) Continue to review Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted SNF/LTC Facilities will be audited at least annually against the audit performed by DHCS. b) All (100%) CAPs generated as a result of the audit will be returned by the due date. c) The number of SNF/LTC Facilities receiving a CAP will be below 10%. d) All (100%) Critical Incident reports will be reviewed for Potential Quality of Care issues.	a) In Q3 18 NF were audited against the audit performed by DHCS. b) Three of the facilities received CAPs. One of the CAPs has been received and two of the CAPs are due in Q4. c)There was one critical incident reported from the NF which was not a PQI.	Continue to provide quality oversight monitoring of the NFs and review critical incident reports for PQI.	Q4 2018	
	IX. QUALITY OF SERVICE										
101	MEMX	Qua ity Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Rating of Health Plan	Implement CG-CAHPS to obtain provider level specific member experience data. Uti ize results from CalOptima's CG-CAHPS survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan. Contract with vendor to implement Provider Coaching to improve provider satisfaction and overall member experience.	Adult Medicaid: 2.43 (50th Percentile) Child Medicaid: 2.57 (50th Percentile) OneCare Medicare: 86% (CMS 4 star goal) OneCare Connect: Medicare: 86% (CMS 4 star goal)	OC Medicare: 85% (3 star) OCC Medicare: 85% Contract has been signed and executed with SPH Analytics to field the CG-CAHPS Survey in 2019. A kick-off meeting with SPH Analytics has taken place in November. Provider Coaching coaching begin with an outreach to middle peforming targeted CCN providers. This outreach strategy yielded low participation. Provider coaching was then expanded to include the health networks in the outreach efforts and also targeted physicians with a large volume of grievances and PQIs. Progess--to-date for shadow coaching: - 6 providers have received coaching - 5 providers are scheduled for coaching for December 2018 - A lot of interest from the health networks to have their providers participate Progess--to-date for workshop: - 1 customer service office staff workshop on November 2 2018 - 1 customer service office manager workshop on November 2 2018 - Office staff training at December CCN Lunch and Learn	Continue to work with SPH Analytics to field the CG-CAHPS survey. Continue to work with our health networks on provider shadow coaching and customer service and other workshops	Q4 2018 to Q1 and Q2 2019	
102	MEMX	Qua ity Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Getting Needed Care	Sharing of HN spec fic CAHPS reports member education on referrals and prior authorization processes and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	Adult Medicaid: 2.28 (25th Percentile) Child Medicaid: 2.37 (25th Percentile) OneCare Medicare: 82% (CMS 3 star goal) OneCare Connect: Medicare: 82% (CMS 3 star goal)	OC Medicare: 80% (2 star) OCC Medicare: 78% (low reliability) Continuous monitoring of CalOptima members' ability to access care. Shared plan and health network level CAHPS at committees and forums. Health network specific CAHPS were be shared with each health network at either the HN Quality Meetings or their JOMS. Passed a l network adequacy requirements. Developed and kicked-off a workgroup to improve member experience with referrals and authorizations.	Continue to monitor network adequacy. Issue a more prescriptive Quality Improvement Plans to the health networks who did not meet the access standards including CCN.	Q4	
103	MEMX	Qua ity Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Getting Care Quickly	Sharing of HN spec fic CAHPS reports member education on referrals and prior authorization processes and review and monitoring of timely access and appointment ava lability standards will improve rating of Getting Care Quickly.	Adult Medicaid: 2.33 (25th Percentile) Child Medicaid: 2.54 (25th Percentile) OneCare Medicare: 79% (CMS 4 star goal) OneCare Connect: Medicare: 76% (CMS 3 star goal)	OC Medicare: 76% (2 star) OCC Medicare: 76% Continuous monitoring of CalOptima members' ability to access care. Shared plan and health network level CAHPS at committees and forums. Health network specific CAHPS were be shared with each health network at either the HN Quality Meetings or their JOMS. Passed a l network adequacy requirements. Developed and kicked-off a workgroup to improve member experience with referrals and authorizations.	Continue to monitor network adequacy. Issue a more prescriptive Quality Improvement Plans to the health networks who did not meet the access standards including CCN.	Q4	

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104	MEMX	Qua ity Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service. Contract with vendor to implement Provider Coaching for Customer Service staff.	Adult Medicaid: 2.54 (50th Percentile) Child Medicaid: 2.50 (25th Percentile) OneCare Medicare: 89% (CMS 3 star goal) OneCare Connect: Medicare: 89% (CMS 3 star goal)	OC Medicare: 87% (1 star) OCC Medicare: N/A (very low reliability) Provider Coaching coaching begin with an outreach to middle peforming targeted CCN providers. This outreach strategy yielded low participation. Provider coaching was then expanded to include the health networks in the outreach efforts and also targeted physicians with a large volume of grievances and PQIs. Progess--to-date for shadow coaching: - 6 providers have received coaching - 5 providers are scheduled for coaching for December 2018 - A lot of interest from the health networks to have their providers participate Progess--to-date for workshop: - 1 customer service office staff workshop on November 2 2018 - 1 customer service office manager workshop on November 2 2018 - Office staff training at December CCN Lunch and Learn	Continue to work with our health networks on provider shadow coaching and customer service and other workshops	Q4 2018	
105	MEMX	Qua ity Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Care Coordination	Provider and office staff in-service on best practices to better coordinate care for members w ll improve rating on Care Coordination.	Adult Medicaid: 2.34 (25th Percentile) Child Medicaid: 2.36 (25th Percentile) OneCare Medicare: 85% (CMS 3 star goal) OneCare Connect: Medicare: 85% (CMS 3 star goal)	OC Medicare: 81% (1 star low reliability) OCC Medicare: N/A (very low realiability) Developed and kicked-off a workgroup to improve member experience with referrals and authorizations.	Continue to have the workgroup meet and map out the referral and authorization process to identify barriers and opporunities for improvement.	Q1 2019	
107	MEMX	Customer Service	Belinda Abeyta/ Albert Cardenas/L. Nguyen	Customer Service Access	Customer Service call lines evaluated for average speed to answer; Customer Service call line evaluated for call abandonment rate	Customer Service lines monitored for average speed to answer; Customer service lines monitored for abandonment rate	ASA 30 Seconds <5% First Call Resolution 85%	**Medi-Cal:** ASA - 27 Seconds: Target Met ABD:1.7%: Target Met First Call Resolution: 84% Target Not Met	**Medi-Cal:** Continued monitoring of staff. Seek opportunities for improvement.	3Q	
108	MEMX	GARS	Ana Aranda/Laura Guest	Review and Report GARS for all Lines of Business. Include review of quality issues (QOC QOS Access) related to member experience.	Global review of member "pain points"; assure appropriate actions are taken to assist the member experience and present data to the Member Experience Committee and QIC	a) Quarterly review of all GARS data to identify issues and trends; including Health Network b) Implement any necessary corrections c) Review health network quarterly totals of grievances d) Conduct causal analysis and determine plan of action for "pain points" that affect member experience	Meet GARS Regulatory Turnaround Times 100%. Improve member experience as measured by improved CAHPS scores.	GARS provided a high level overview of Q2 2018 data. No outstanding issues.	Q3 will be presented at next member experience committee. Need to confirm date.	4Q	
109	MEMX	Pharmacy	Kris Gericke	Member Accessing Pharmacy Benefit Information	Maintain member access to their pharmacy benefit and the operations of network pharmacies through the CalOptima website or through telephone communication with CalOptima Customer Service staff	Monitor and annua ly report requirements for NCQA Member Connection 4: Pharmacy Benefit Information Standards	Via the CalOptima website Members are able to: -Submit Prior Authorization requests; -Conduct network pharmacy proximity searches based on zip code; -Find information on potential drug-drug interactions common side effects and sign ficant risks and availability of generic substitutes; and -Receive responses to pharmacy inquiries within twenty-four (24) hours (or next business day).	2Q18 MEM 4 website access testing passed all elements.	Continue to monitor quarterly reports.	4Q	
	X. NETWORK ADEQUACY										

#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
110	MEMX	Customer Service/ Network Management	Belinda Abeyta/ Jennifer Bamberg	Notification to Member when Practitioners Terminate.	Members are notified when Practitioners Terminate.	Termination of Practitioners is monitored through monthly CT forms that are submitted to PDMS. 1) Members are notified of terminated practitioners with 30 days from when CalOptima is notified 2) Network is monitored to determine if adjustments to network are necessary.	Notification to members are within 30 days of notification to CalOptima 85% of the time.	**Medi-Cal:** Achieved 100% for member notification within 30 days of provider termination.	**Medi-Cal:** Continue to monitor and report.	3Q	
111	MEMX	Qua ity Analytics	Marsha Choo	Review of access to care non-urgent primary care appointments	1. Non-urgent primary care appointments within 10 business days of request	Data against goals w ll be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Appointment: 90% minimum performance level	For MY 2017 CalOptima met this standard at the plan level. Prescriptive Quality Improvement Plans to be issued to health networks who did not meet the access standards including CCN for MY 2017. Timely Access Survey was not fielded in 2018 due to change in vendor and data collection methodology to add mystery shopper calls. Contract with new vendor was executed in November 2018.	QIPs to be issued in December 2018. Kick of meeting with vendor in December 2018. Fielding to occur in Q1 and Q2 2019.	Q4 2018	
112	MEMX	Qua ity Analytics	Marsha Choo	Review of availability of primary care practitioners (min. provider ratios)	Primary care practitioner availability (min. provider ratio) is measured assessed and adjusted to meet standard	Data against goals w ll be measured and analyzed for the fo lowing through the implementation of our provider data pull from FACETS.. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	CalOptima met the regulatory requirements at the plan level for all lines of business. For MC OB-GYNs are now separated into 2 categories: PCP or Specialist. The Access and Availability Sub-Committee may need to review the standard due to this change. Continue to monitor.	Continue to monitor. Share availablility performance with health networks.	Q4 2018 Q1 2019	
113	MEMX	Qua ity Analytics	Marsha Choo	Review of availability of primary care practitioners (geographic distribution)	Primary care practitioner availability (geographic distribution) is measured assessed and adjusted to meet standard	Data against goals w ll be measured and analyzed for the fo lowing through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	CalOptima met the regulatory requirements at the plan level for all lines of business. For Medi-Cal due to a few members in South County CalOptima did not meet the standards now that the minimum performance is set at 100%. Continue to monitor.	Continue to monitor and look into these few members in South County. Share availablility performance with health networks.	Q4 2018 Q1 2019	

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#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
114	MEMX	Qua ity Analytics	Marsha Choo	Review of availability of specialty practitioners (min. provider ratios)	High volume and high impact specialty availabi ity (practitioner to member ratio) is measured assessed and adjusted to meet standard	Data against goals w ll be measured and analyzed for the following through the implementation of our provider data pull from FACETS.. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	CalOptima met the regulatory requirements at the plan level for all lines of business. For Medi-Cal due to a few members in South County CalOptima did not meet the standards now that the minimum performance is set at 100%. Continue to monitor.	Continue to monitor and look into these few members in South County. Share availablility performance with health networks.	Q4 2018 Q1 2019	
115	MEMX	Qua ity Analytics	Marsha Choo	Review of availability of specialty practitioners (geographic distribution)	High volume and high impact specialty availabi ity (geographic distribution) is measured assessed and adjusted to meet standard	Data against goals w ll be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	CalOptima met the regulatory requirements at the plan level for all lines of business. For Medi-Cal due to a few members in South County CalOptima did not meet the standards now that the minimum performance is set at 100%. Continue to monitor.	Continue to monitor and look into these few members in South County. Share availablility performance with health networks.	Q4 2018 Q1 2019	
116	MEMX	Qua ity Analytics	Marsha Choo/ Edwin Poon	Review of availability of behavioral health practitioners (min. provider ratios)	Behavioral Health practitioner availabi ity (practitioner to member ratio) is measured assessed and adjusted to meet standard	Data against goals w ll be measured and analyzed for the following through the implementation of our provider data pull from FACETS.. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	CalOptima met the regualtory requirements at the plan level. Continue to monitor.	Continue to monitor	Q4 2018	
117	MEMX	Qua ity Analytics	Marsha Choo/ Edwin Poon	Review of availability of behavioral health practitioners (geographic distribution)	Behavioral Health practitioner availability (geographic distribution) is measured assessed and adjusted to meet standard	Data against goals w ll be measured and analyzed for the fo lowing through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	CalOptima met the regulatory requirements at the plan level for all lines of business. For Medi-Cal due to a few members in South County CalOptima did not meet the standards now that the minimum performance is set at 100%. Continue to monitor.	Continue to monitor and look into these few members in South County. Share availablility performance with health networks.	Q4 2018 Q1 2019	

#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
118	MEMX	Pharmacy	Kris Gericke	Network Pharmacy Access	Network pharmacy ava lability (geographic distribution) is measured and assessed to meet the standard	Quarterly GeoAccess report	Pharmacy Network Access Requirements: -At least ninety percent (90%) of Members on average in urban areas live within two (2) miles of a Participating Pharmacy; -At least ninety percent (90%) of Members on average in suburban areas live within five (5) m les of a Participating Pharmacy; and -At least seventy percent (70%) of Members on average in rural areas live within fifteen (15) miles of a Participating Pharmacy	2Q18 network access requirements met.	Continue to monitor quarterly reports.	4Q	
119	CPRC	Qua ity Improvement	Esther Okajima/ Melinda Enos	Credentialing Of Provider Network Is Monitored	Credentialing program activities monitored for volume and timeliness	New applicants processed within 180 calendar days of receipt of application; Report of initial credentialing file activity to CPRC	90% of initial credentialing applications are processed within 120 days of receipt of application	In Q3 90 initial files and 166 recredentialing files for a total of 256 practitioner and HDO files were completed and approved. Processing times average 100 days for practitioners and 80 days for HDOs however the backlog of files still result in only 44% of the files processed in less than 120 days. This workplan element continues to be a concern and at risk for delaying the approval of practitioners into the network.	Work with process exce lences to determine the barriers to the backlog and TAT	Report in Q4.	
120	CPRC	Qua ity Improvement	Esther Okajima/ Melinda Enos	Recredentialing Of Provider Network Is Monitored	Recredentialing of practitioners is completed timely	Recredentialing is processed every 36 months; Report of Admin term due to missed recredentialing cycle; Report of re-credentialing activity to CPRC	100% of all recredentialing f les are processed within 36 months of last credentialing date	In Q3 3 recredentialing files exceeded the 36 month time limit for recredentialing files. The 3 that exceeded the time frame was due to issues identified in CPRC and the fact that many of the files were approved in the month that they were due. This does not allow for any margin if a file eneded further investigation.	Work with contracting and PR to identify those files that require additional time and bring them to CPRC sooner than later to ensure timeliness standards are met.	Report udpate in Q4	
121	MEMX	Qua ity Analytics	Marsha Choo	Review of access to care for urgent appointments	1. Urgent care appointments without prior authorization within 48 hours of request 2.Urgent appointments with prior authorization with 96 hours of request	Data against goals w ll be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Appointment: 90% minimum performance level	Prescriptive Quality Improvement Plans to be issued to health networks who did not meet the access standards including CCN for MY 2017. Timely Access Survey was not fielded in 2018 due to change in vendor and data collection methodology to add mystery shopper calls. Contract with new vendor was executed in November 2018.	QIPs to be issued in December 2018. Kick of meeting with vendor in December 2018. Fielding to occur in Q1 and Q2 2019.	Q4 2018	
122	MEMX	Qua ity Analytics	Marsha Choo	Review of access to care specialty appointments	1. Appointment with specialist within 15 business days of request 2. Non-urgent non-physician mental health appointment within 10 business days of request 3. First pre-natal visit within 10 days	Data against goals w ll be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks including the CalOptima Community Network for areas of non-compliance.	Appointment: 90% minimum performance level	Prescriptive Quality Improvement Plans to be issued to health networks who did not meet the access standards including CCN for MY 2017. Timely Access Survey was not fielded in 2018 due to change in vendor and data collection methodology to add mystery shopper calls. Contract with new vendor was executed in November 2018.	QIPs to be issued in December 2018. Kick of meeting with vendor in December 2018. Fielding to occur in Q1 and Q2 2019.	Q4 2018	
	XI. COMPLIANCE										

#	Reports to	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target (3Q)
123	AOC	A&O	Solange Marvin/Karla Gutierrez	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	98%	**Medi-Cal** Utilization Management (UM): Summary of Findings of file Review for Uti ization Management decisions (July 20 8 - September 2018) – The Ut lization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. Claims(CL): Summary of Findings of file Review for Claims (July 2018 - September 2018) - Claim payment obligations and claims settlement practices are reviewed to assure they are paid accurately to the requirements and are processed within the appropriate timeframe. **OneCare** Utilization Management (UM): Summary of Findings of file Review for Uti ization Management decisions (July 2018 - September 2018) – The Ut lization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. Claims(CL): Summary of Findings of file Review for Claims (July 20 8 - September 2018) - Claim payment ob igations and claims settlement practices are reviewed to assure they are paid accurately to the requirements and are processed within the appropriate timeframe. **OneCare Connect** Utilization Management (UM): Summary of Findings of file Review for Uti ization Management decisions (July 20 8 - September 2018) – The Ut lization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. Claims(CL): Summary of Findings of file Review for Claims (July 2018 - September 2018) - Claim payment obligations and claims settlement practices are reviewed to assure they are paid accurately to the requirements and are processed within the appropriate timeframe. **All LOB:** Credentialing (CR): Credentialing and Recredentia ing activities are reviewed to assure they are performed in accordance with quality state and federal standards. (July 2018 - September 2018).	Next Step: Corrective Action Plan issued and continued monitoring from performance Improvement.	Ongoing	
124	AOC	Case Management	Sloane Petrillo	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	HN to achieve 90% on file review monthly	AltaMed did not meet goal for one month. CHOC did not meet goal for one month. Regal did not meet goal for one month. Prospect did not meet goal for two months. UCMG did not meet goal for two months.	Continue monthly review. Letters sent to networks that are not demonstrating improvement trend. Discussed at JOM.	12/31/2018	

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PACE Quality Improvement Committee Meeting Minutes May 8th, 2018 Time: 10:30am – 12:00pm Place: PACE Conference Room 109
Meeting Attendees: Dr. Miles Masatsugu, Elizabeth Lee, Christine Sisil, Jenny Nguyen, Rebekkah Bitterman, LCSW, Franco Estacio, PT, Noe Zuniga, Eva Elser, Dr. Arghami, Dr. Nguyen, Viri Chavez
Meeting Notes Taker: Jenny Nguyen

Topic	Presentation/Discussion	Actions	Owner/Leader	Due Date
Roll Call and Introduction	Meeting called to order by Dr. Masatsugu at 10:38 a.m.	N/A	Miles Masatsugu, MD	
OLD BUSINESS				
Review and Accept Previous PQIC Minutes	Minutes of the PQIC March 13, 2018 approved.	First by Christine Sisil second by Noe Zuniga	Miles Masatsugu, MD	
QAPI Work Plan 2018 Q1 Analysis PPP	Audit Findings – Dr. Miles Masatsugu discussed findings of the most recent PACE Audit. Overall, PACE did well. CMS and DHCS felt that there were no issues with the care being provided. Preliminarily, the area identified as having the best opportunity for		Elizabeth Lee	

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	improvement had to do with the service delivery requests. New QAPI Items – Elements 13-15 (HEDIS DDE) has been added to the 2018 QAPI plan in order to compare the care PACE participant's receive with other CalOptima's lines of business and national benchmarks. Membership – As of May 2018, there are 262, 9 shy of the projected 271 according to Enrollment & Marketing Manager, Noe Zuniga. However, there are currently 17 home visits scheduled in May. Immunizations – Pneumococcal in Q1 2018 was at 90%. There were 245 eligible participants with 23 missed opportunities. According to Clinic Manager Christine Sisil, 12 pneumococcal vaccines were given in April. According to Christine, missed opportunities were due to not having past records or was missed by staff. For influenza, 26 had missed opportunities. Upon review, 9 influenza vaccines were given in April leaving 17 missed opportunities. The rate for Q1 2018 is 89%. The missed opportunities are primarily new enrollees whose records were being retrieved. According to committee members Dr. Arghami, Dr. Thuy, and Dr. Miles, if a participant does not have the vaccine, PACE will administer the vaccine instead of waiting for records.	Implement new immunization workflow. Continue to track and trend.	Miles Masatsugu, MD Noe Zungia Christine Sisil and Elham Arghami, M.D.	

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	Infection Control – Rates still trending well below national benchmarks. Respiratory infection rate is at 0.65 episodes per 1000 participant days and skin/soft tissue is at 0.45 episodes per 1000 participant days. POLST – PACE continues to have 100% of participants with a completed POLST. According to Dr. Miles, PACE's rate is much higher than other health plans and CBAS centers. It is very impressive. Care for Older Adults – In Q1 2018, PACE completed 100% in medication reviews, functional status assessments, and pain screenings. By comparison, CalOptima's OneCare Connect had the final 2017 results which were 29.66%, 28.69%, and 30.48% respectively. Overall, very impressive, Diabetic Eye Exams – In Q1 2018, the goal was changed from 90% to 83.10% to align with the Medicare Quality Compass (90th percentile). Although in Q1 2018, PACE met this goal, it is a decrease from Q4 2017. Part of the reasons for the decrease is due to issues related to an inability to obtain past medical records for new enrollees who reported that they have received a diabetic eye exam in a timely manner. Dr. Miles suggested a process in which orders be placed for those the PACE Clinic cannot obtain past medical records for. In addition, placing standing orders to ensure annual exams was discussed. Director Elizabeth Lee stated that prior to	Continue to track and trend. Continue to track and trend. Implement standing orders and new participant orders.	Christine Sisil and Elham Arghami, M.D. Rebekkah Bitterman Christine Sisil and Elham Arghami, M.D. Christine Sisil and Elham Arghami, M.D.	

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	Q2 2017, rates were much lower. An increase in the rate shows that paying more attention to a certain element will make a difference. Medication Reconciliation Post-Discharge – There were 50 admissions in Q1 with all receiving a reconciliation. Records are reviewed for post-discharge visits with PCP or a pharmacist reconciliation of medications. According to Dr. Arghami, the process is that physicians will review medications while PACE LVN requests for records. No other comments. Specialty Rate (Access and Availability) – Dr. Miles provided a brief background on turn-around times on a health plan level. Clinic Manager Christine Sisil states that UCI has transitioned to a new electronic health system causing a delay in scheduling consults in January and February. Related to specialty referrals, Dr. Miles states to report on the number of absolute referrals for the next meeting in order to see effectiveness of interventions. The team is currently working on a number of items related to specialty care. First, PACE is moving towards having internal staff members do nail clippings to decrease the need for podiatry visits. Second, PACE has developed a relationship with an Optometrist to do the initial eye screenings. Staff has also placed funds in the budget to purchase Otometry equipment. After that occurs, the Optometrist will be coming to the clinic see participants. Third, Dr. Miles has	Continue to track and trend. Continue to track and trend.	Christine Sisil and Elham Arghami, M.D. Dr. Miles and Dr. Arghami	

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	spoken to the Podiatrist, Optometrist and Ophthalmologist to provide a better understanding of the PACE model and our desire to have consultations and recommendations as opposed to management of stable medical issues. As the number of referrals for Podiatry and Ophthalmology decreases, the specialty rate should increase due to the volume of referrals. Hospital Bed Days –Dr. Miles asked committee member Dr. Thuy Nguyen if he can attribute this rate to any interventions. According to Dr. Thuy Nguyen, the flu season is over and PACE physicians have started to isolate more complex cases. In comparison to the CalPACE average, it appears that CalOptima is within the average of other plans. One of the main drivers to admission has to do with the fact that the PACE members are very frail with complex medical issues and often a number of functional dependencies. Because of this, when they go to the ER, they are often admitted unnessearily. The main goal is to evaluate the participants in real time to allow for the appropriate level of care with the goal of reducting inappropriate hospitalizations. ER Visits – Although there is an increase in ER Visits, Dr. Miles believe that PACE's ER Diversion program will soon make an impact. Readmission – Currently readmission rates are below CalPACE averages. This is most likely due to the fact	Continue to track and trend. Continue to track and trend. Continue to track and trend.	Dr. Miles and Dr. Thuy Dr. Miles and Dr. Thuy Dr. Miles and Dr. Thuy	

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	that the PACE PCPs providing inpatient care are also seeing participants in the PACE clinic which allows for much better continuity and coordination of care. PACE is currently right on target with the goal. Enrollments – Marketing and Enrollment Manager Noe Zuniga commented on barriers in Q4 2017 which are the holiday months. Historically, Q4 runs low due to travel plans and flu seasons. To combat this, Noe and the enrollment team has started a mailer. Although the mailer came out slightly late, we can still see an increase at the very end of Q4 and into Q1 2018. In terms of growth, PACE can start marketing for South County on July 1st, 2018. Dr. Miles commented that it is possible that there will need to be two enrollment teams just to assist in the expansion growth. Dr. Miles believes that community-based physicians, service area expansion, and alternative care settings will drive enrollment in the upcoming months. Additional resources have been discussed to accommodate a possible increase in enrollment. Currently, the enrollment team is maximizing resources by attempting to increase the conversion rate of prospective participants. Disenrollments –Disenrollments are very low. This correlates with the Annual Participant Satisfaction report. Marketing and Enrollment manager commented that assessing appropriateness really helps on the front end to address disenrollments. Rehab supervisor Franco Estacio also commented	Continue to track and trend. Continue to track and trend.	Zoe Zuniga Management Team	

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	that having two IDT helps due to the ability to assess clinical appropriateness. Having alternative care settings will also contribute to this as capacity at the center will decrease. Transportation – Numbers look good as there are no one-hour violations. Grievances have decreased related to transportation. Director Elizabeth Lee believes that there may be more grievances related to fleet changes as PACE is adding an additional five vehicles within the next few months.	Continue to track and trend.	Elizabeth Lee	

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	Meeting adjourned at 11:27 a.m.			

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PACE Quality Improvement Committee Meeting Minutes August 7th, 2018 Time: 10:30am – 12:00pm Place: PACE Conference Room 109
Meeting Attendees: Dr. Miles Masatsugu, Christine Sisil, Jenny Nguyen, Rebekkah Bitterman, LCSW, Franco Estacio, PT, Noe Zuniga, Eva Elser, Dr. Arghami, Dr. Nguyen, Viri Chavez
Meeting Notes Taker: Jenny Nguyen

Topic	Presentation/Discussion	Actions	Owner/Leader	Due Date
Roll Call and Introduction	Meeting called to order by Dr. Masatsugu at 10:38 a.m.	N/A	Miles Masatsugu, MD	
OLD BUSINESS				

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Review and Accept Previous PQIC Minutes	Minutes of the PQIC June 12, 2018 approved.	Motion to approve by Viri Chavez. Seconded by Cynthia Stivers	Miles Masatsugu, MD	
NEW BUSINESS				
QAPI Work Plan 2018 Q2 Analysis PPP	Membership – Overall, our membership is doing well. Noe Zuniga shared that flyers are going out to drive membership. Enrollment team is diversifying their membership approach, i.e. building expansion relationships with different providers (UCI, Dialysis Centers). Noe Zuniga states that the approach in enrollment is to promote PACE as a program as opposed to a Center. This conveys the message that the Center in Garden Grove has other options for potential enrollees (i.e. Acacia, South County, Santa Ana, etc.). In August, 13 new enrolled with 5 disenrollments . For September capitation, 14 home visits are scheduled with a projection of 9-11 enrolled. Dr. Masatsugu is interested in understanding what the maximum number of potential participants the enrollment team can evaluate a month. Dr. Masatsugu is asking that Enrollment and IDT look at their teams and advise as to their maximum capacity.	IDT and Enrollment to look at their teams and advise as to capacity	Noe Zuniga	

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	POLST – PACE continues to have 100% of participants with a completed POLST. According to Dr. Miles, PACE's rate is much higher than other health plans. However, we often run into issues implementing the POLST in acute hospital settings. This is often because family members come to the hospital who are not familiar with the previous discussions and decisions and do not agree with what is outlined in the POLST. Dr. Miles spoke with Dr. Nguyen who is the director of the Hoag Palliative Care Program who recommended that we make a concerted effort to get as much family involvement as possible when completing/reviewing the POLST. Dr. Nguyen recommended having the family designate a decision maker for the family who is present when the POLST is completed and who is participants family's point person.	Dr. Thuy Nguyen and Rebecca Bitterman to develop a workflow to designate family member who is the decision maker when a POLST is drawn.	Monica Macias	
	Functional Assessments –Jenny Nguyen explained that functional status assessments are required per regulation every 6 months for PCP, RN, PT and SW. QI sends out a monthly report of missing care plans and assessments.	Continue to track and trend	Monica Macias	
	Diabetic Eye Exams – Percentage of participants with DM eye exam within 1 year is 94% which exceeds our goal of greater than 83.1%.	Continue to track and trend.	Dr. Masatsugu	

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	Nephropathy Monitoring and Blood Pressure Control – 99% exceeding our goal of 79.32%	Continue to track and trend.	Dr. Masatsugu	
	Medication Reconciliation Post-Discharge – Rate is 97% which exceeds our goal of 90%. Success is due to the Medication LVN receiving the Medication Reconciliation from the RN Case Manager and forwards this to the provider for reconciliation. Additionally, all participants are scheduled for a follow-up visit with their provider within a week of discharge.	Continue to track and trend	Christine Sisil, RN	
	Specialty Rate (Access and Availability) – Discussion regarding the higher acuity population of PACE participants and the challenge to address proper coding to confirm the acuity of our patients. Providers will be having a training based on the findings of the Coding Audit.	Continue to track and trend.	Dr. Masatsugu	
	Hospital Bed Days –Committee noted trends.	Continue to track and trend.	Dr. Masatsugu	
	ER Visits – 6 participants make up 60% of the ER admissions, with dialysis patients being the majority of the admits.	Continue to track and trend	Dr. Masatsugu	
	Readmission – Currently readmission rates are below CalPACE averages.	Continue to track and trend	Dr. Masatsugu	

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	Disenrollments –Disenrollments are low. 3 participants disenrolled within 90 days with loss of eligibility being the primary reason for disenrollment.	Continue to track and trend	Noe Zuniga	
	Transportation – One participant was affected by the one-hour violation rule. A change in assigned route attributed to this.	Continue to track and trend	Monica Macias	
Request Approval of updated Desk Reference	QI Manager Eva Elser presented an updated Desk Reference for Grievances and Appeals. Dr. Masatsugu requested the wording related to extensions be changed to read “8 calendar days”. Dr. Masatsugu motioned to approve. Seconded by Christine Sisil.			
Priorities for Resource Allocation	Audit Remediation and implementing corrective action: For the months of June and July, we were 100% in compliance with CAP’s related to SDR’s. For remediation for in-person assessments, we are 91% in compliance. We are 100% in compliance with timely personnel competencies. For those CAP’s which required immediate corrective action (ICAR’s) we are 100% in compliance with the 72-hour rule of participant assessment following a SDR. We are making progress on conducting annual/semiannual reassessments for PT and OT. In June, 31% of the participants who needed reassessments during the audit period, were	Follow up with regulatory affairs regarding recommended working to indicate skilled therapy vs. functional maintenance.	Monica Macias	

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	completed. By July, 48% of the participants had reassessments completed. Community-based Physicians: An implementation team has been formed. The plan is to have the community-based physicians in-house for a couple of days/week for a few months for training. Utilization Management: House Call Medical Associates is providing after-hours on call coverage. HCMA is piloting an emergency room diversion program by providing other options, (e.g. nurse home visit, direct SNF admission). The committee discussed IDT authorization of hospital days with recommendation to use the following language: "participant hospitalized for *diagnosis*, authorization pending receipt of records", "participant hospitalized for *diagnosis*, recommend authorization for 2 days". Prior Authorizations: Focus resources on studying specialty follow-up visits.	Update Reassessment Care Plan Desk Reference Refine workflow for discharge planning upon inpatient hospital notification.	Mardany Escobedo, QI Dr. Masatsugu, RN Case Manager	
	Meeting adjourned at 11:53 a.m.			

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PACE Quality Improvement Committee Meeting Minutes November 27, 2018 Time: 10:30am – 12:00pm Place: PACE Conference Room 109
Meeting Attendees: Dr. Miles Masatsugu; Elizabeth Lee; Christine Sisil, RN; Jenny Nguyen, Rebekkah Bitterman, LCSW; Mardany Escobedo, Franco Estacio, PT; Noe Zuniga, Monica Macias, LCSW; Dr. Thuy Nguyen, Viri Chavez; Eva Elser, RN
Meeting Notes Taker: Eva Elser

Topic	Presentation/Discussion	Actions	Owner/Leader	Due Date
Roll Call and Introduction	Meeting called to order by Dr. Masatsugu at 10:33 a.m.	N/A	Miles Masatsugu, MD	
OLD BUSINESS				
Review and Accept Previous PQIC Minutes	Minutes of the PQIC August 7, 2018 approved.	First by Christine Sisil	Miles Masatsugu, MD	

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Updates	**Review of House Call Medical After-Hours Service:** Dr. Masatsugu reported that there are not many after-hour calls. It appears that most participants go to the ER on their own. Dr. Masatsugu spoke about the benefits of using HCMA, where the on-call provider can triage and has the option of conferring with the ER physician. Dr. Masatsugu also recommended that a single person in the clinic notify the on-call HCMA physician of intended ER admits. Transportation: Dr. Masatsugu indicated that HCMA have continued issues with transportation following discharges from facilities.	Identify a single person in the clinic to notify on-call provider of participants sent to the ER	Miles Masatsugu, MD	
	Audit Controls: Eva Elser summarized the 2018 DHCS/CMS audit with a power point presentation. The auditor's focus was highlighted. Deficiencies (mainly centered around SDR's) which were cited have been addressed by re-designs of our workflow and training. Monitoring will continue. In July 2018, we received a final letter from CMS indicating that we received a score of 2.2 which places us higher than the norm. Since SDR's were the major impacted area of our deficiencies, Dr. Masatsugu recommended that the SDR process be included on all annual staff competency assessments.	Include the SDR process on the Staff Competency Tool	Eva Elser	
Review HPMS submissions for Q2 2018	**Enrollment:** Noe Zuniga reported that there is a challenge in enrolling participants in that there is an increase in potential participants with psych issues. He anticipates seeing more of these types of		Noe Zuniga and Monica Macias	

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Review HPMS submissions for Q2 2018 – con't	referrals. 46 home visits were conducted during Qtr. 2 with a 61% conversion rate. Monica Macias reported that we have 17 disenrollments in Quarter 2 with the following reasons: moved out of the service area; death; hospice, loss of eligibility. The issue of correctly placing proper reasons for disenrollment codes in TrueChart were discussed. Rebekah Bitterman will follow-up with Jenny on this. Dr. Masatsugu stated that he is most interested in the metrics of (1) 90-day disenrollments (are we screening correctly?); (2) dissatisfaction; (3) hospice.	Reasons for Disenrollment to be placed in TruChart		
	Falls without Injury: Franco Estacio reported that we are seeing a downward trend in falls, primarily due to less frequent fallers. He attributed this to the monthly fall committee and involving the pharmacist in identifying medications which may lead to a fall risk. The overall plan of PT/OT department is to educate the participant's family on fall prevention. When falls occur, they tend to occur in the home in the presence of the family. Our PACE Fall Trends will be presented at the NPA Conference in October. Dr. Masatsugu recommended that in the future, we begin to look at CBAS Centers and PACE at Home and include data in the CBAS reporting.	Include Falls data in the CBAS reporting	Franco Estacio	

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Review HPMS submissions for Q2 2018 – con't	**Grievances:** Eva Elser reported a decline in Qtr. 2 grievances. Four grievances were filed: (1) caregiver issue; (2) dental; (3) untimely receipt of medications; (4) MD prescribing. QI investigated the grievances and are all closed at this point. **Appeals:** Eva Elser reported that one participant filed an appeal related to home delivered meals. The appeal was sent to a 3rd party reviewer who upheld the decision. **QI Events (Level II):** Eva Elser reported a total of 8 Level II events: 5 Falls with injury; 2 Burns and 1 Elopement.		Eva Elser	
Manager's Reports	**Medical Records:** Mardany Escobedo reviewed 148 member months with 261 deficiencies. Findings: assessments not completed as scheduled; PPD's not documented; no measurable goals in the Life Plan; omission of signature on Care Plan; missing demographics; procurement (mainly DME); unsigned requisitions (no date of service). Christine indicated that she would follow-up with the schedulers regarding the requisitions. In the future, Mardany will include sample ACS reviews. **Director's Report:** Elizabeth Lee reviewed the 6/18/2018 PMAC meeting which focused on Dietary Services with the discussion led by Cyndi Stivers.	Schedulers to be re-trained in requisition process	Mardany Escobedo Elizabeth Lee	

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	Transportation: One 1-hour violation. Transportation performance above the 90% metric. Elizabeth is working on the issue of reliance of single-rider trips. Additionally, we are working on increasing the fleet concurrent with enrollment. **Center Manager Report:** There has been a reduction in the disenrollment within 90 days. Disenrollment factors have included wanting to keep their PCP and retaining the IHSS hours. Equipment Logs: Hydrocollator and Paraffin Logs were not adequately completed. Franco Estacio and his team are looking at correcting this. **Clinic Manager:** Christine Sisil reported no issues with Clinic Logs. Respiratory infection and skin infection rates remain below the national benchmark. The Clinic will receive their first vaccine shipment today.	Hydrocollator and Paraffin Logs need to be kept current	Monica Macias Christine Sisil	
Other QI Issues	**UM:** Dr. Miles shared that a Utilization Management Workgroup is being organized. The Workgroup will cover all utilization and calculate resources. **Participant Satisfaction Surveys:** Eva Elser stated that an internal participant satisfaction had been completed with most of the dissatisfaction issues revolving around Dental and Dietary Services. A 3rd party survey through Vital Research will occur beginning 10/8/2018.		Dr. Masatsugu	

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	Staff Flu Shots will be done on-site on 10/18/2018. This will be coordinated by Eva Elser and Jacqueline Nguyen from Environmental Health Services.			
	Meeting Adjourned at 11:55			

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Member Trend Report: Third Quarter 2018

Board of Directors' Quality Assurance Committee Meeting
February 20, 2019

Ana Aranda
Director, Grievance and Appeals

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Overview

- Breakdown of complaints by category
- Trends in rate of complaints (appeals/grievances) per thousand members for all CalOptima programs for third quarter 2018
- 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 the CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction
- Quality of Care (QOC): Concerns regarding the care member received or feels should have been received

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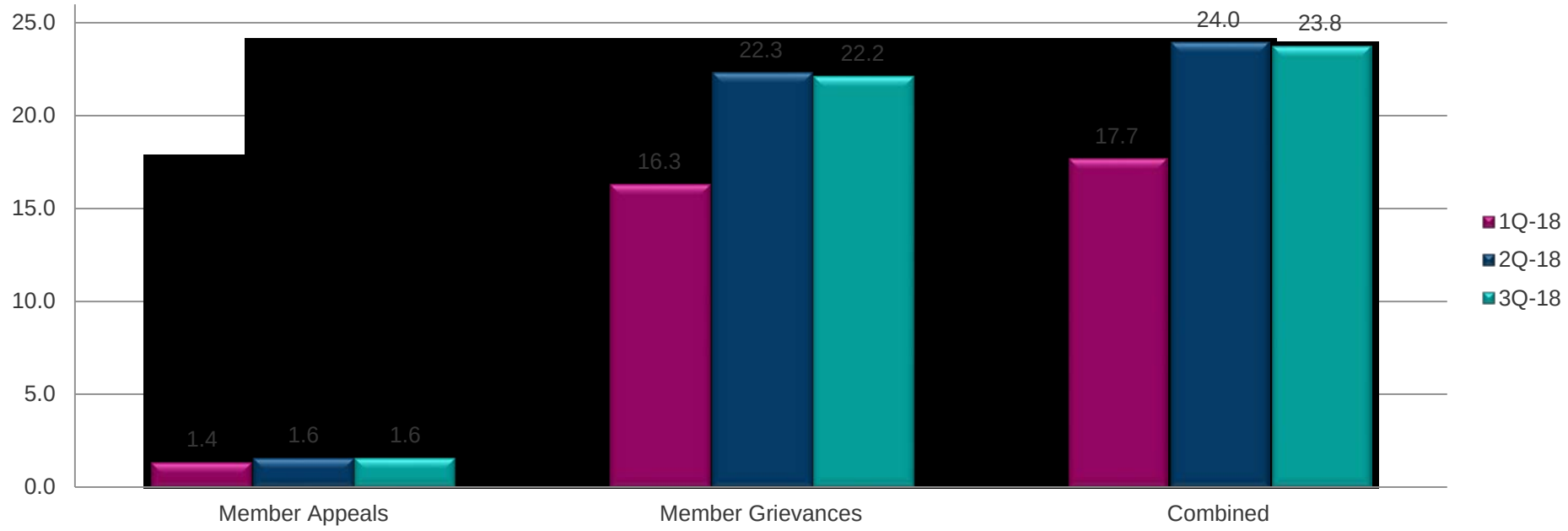
Medi-Cal Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
1Q-2018	3,365	262	3,103	771,453
2Q-2018	4,562	310	4,252	767,616
3Q-2018	4,521	307	4,214	763,233

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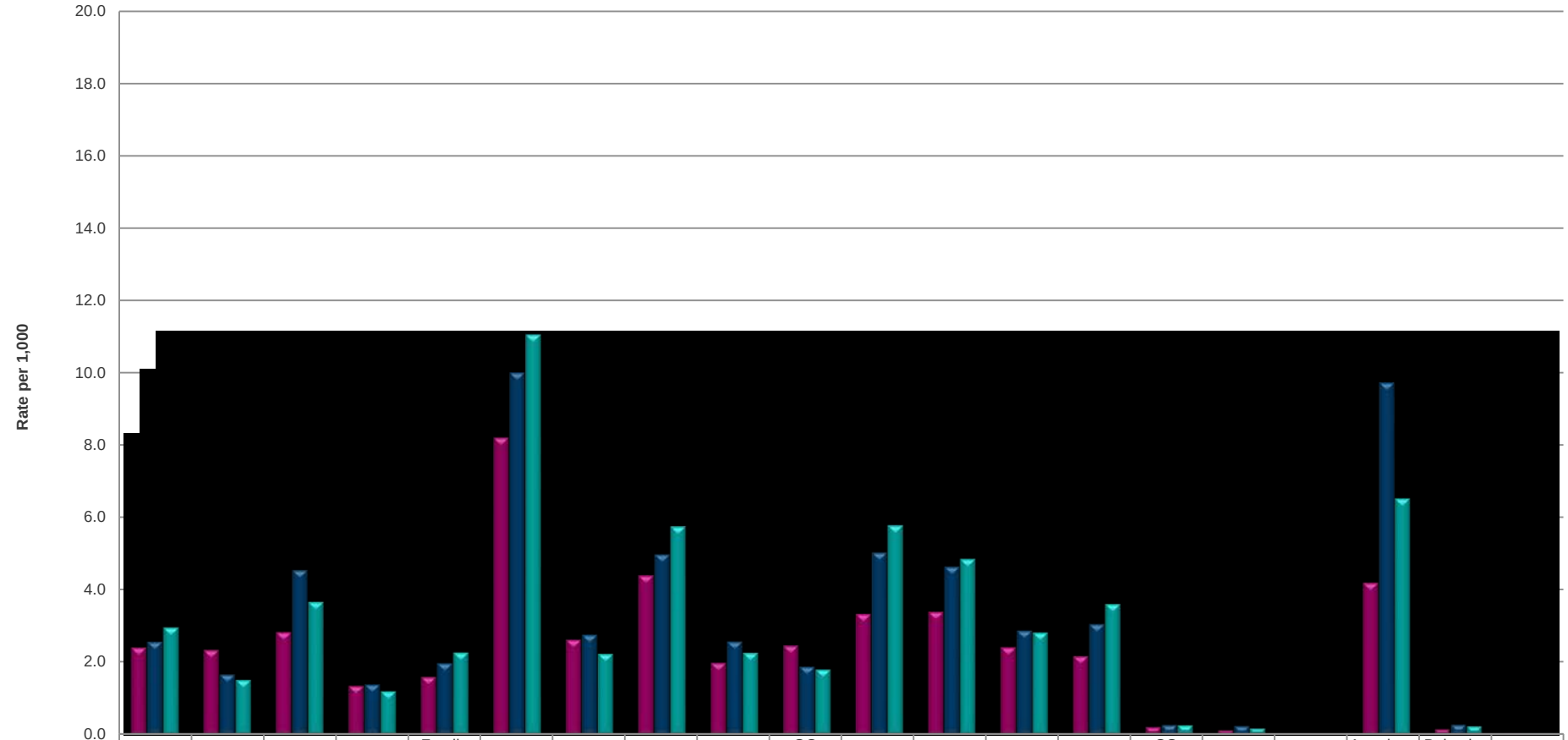
Medi-Cal Member Grievances Quarterly Rate/1,000



	AltaMed (46,603)	AMVI (22,295)	Arta (65,313)	CHA (147,070)	Family Choice (46,250)	Heritage (5,971)	Kaiser (45,734)	Monarch (81,273)	Noble (24,564)	OC Advantage (2,199)	Prospect (34,052)	Talbert (24,008)	UCMG (32,387)	COD (100,737)	CO Pharm (708,731)	CO Prog (754,465)	MLTSS (708,731)	American Logistics (29,729)	Behavioral Health (754,465)	VSP (708,731)
1Q-18 (3103)	2.42	2.35	2.85	1.36	1.61	8.21	2.64	4.40	2.00	2.47	3.35	3.41	2.43	2.18	0.21	0.12	0.00	4.20	0.15	0.03
2Q-18 (4252)	2.58	1.67	4.55	1.40	1.99	9.99	2.78	4.98	2.59	1.89	5.04	4.65	2.89	3.07	0.27	0.25	0.00	9.71	0.28	0.03
3Q-18 (4214)	2.98	1.53	3.69	1.21	2.29	11.05	2.25	5.76	2.28	1.82	5.79	4.87	2.84	3.63	0.27	0.17	0.00	6.53	0.23	0.02

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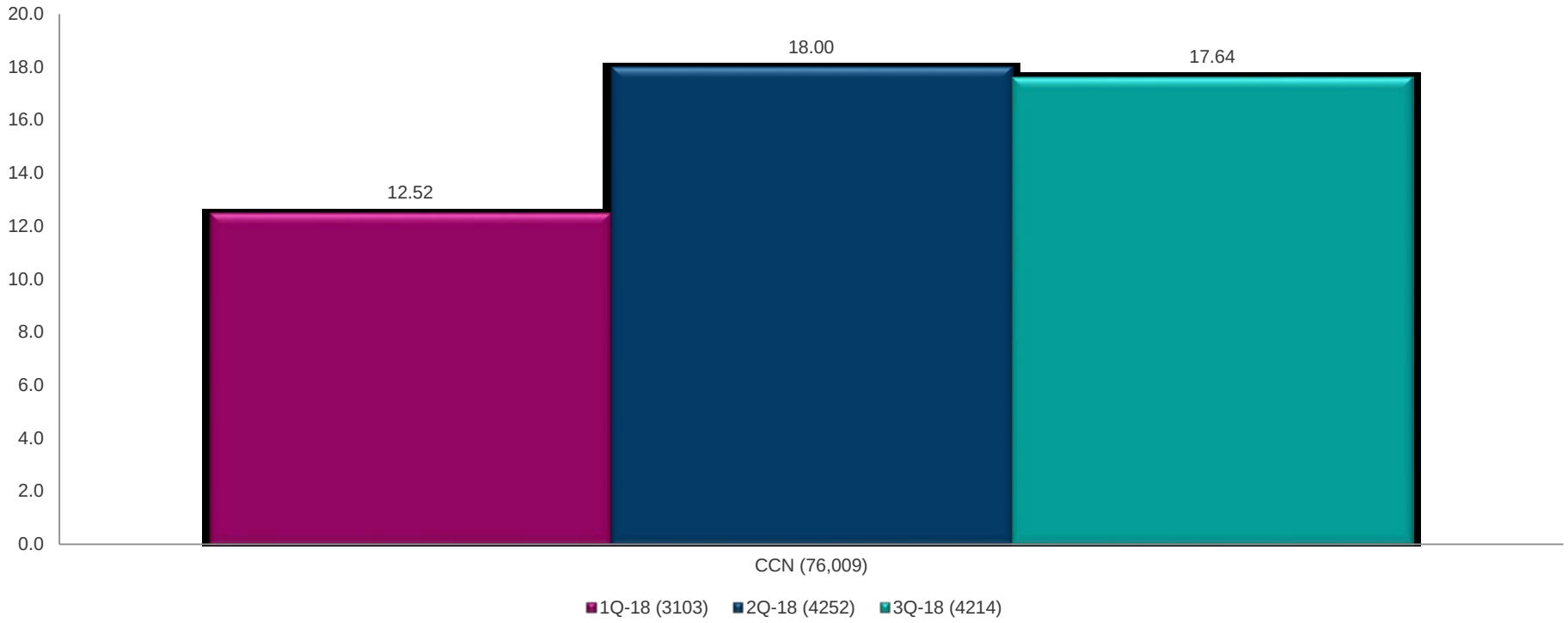
CalOptima A Public Agency Better. Together.

CCN Medi-Cal Grievances
Quarterly Rate/1,000 Members



- CalOptima Community Network (CCN) grievances decreased from 1,357 in Q2, 2018 to 1341 in Q3, 2018
  - Top grievances include delays in service, provider/staff demeanor and questioning of care/treatment.

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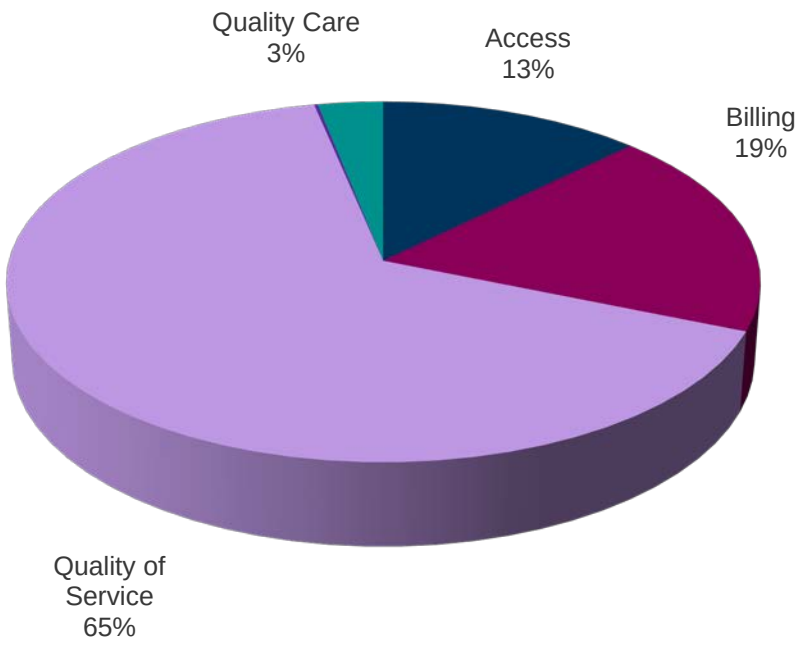
Medi-Cal Grievances by Category

- Quality of Service includes:
  - Delays in service
  - Provider services
  - Transportation (NMT) Services

- Access includes:
  - Appointment availability
  - Specialty care referrals
  - Telephone accessibility

- Billing includes:
  - ✓Reimbursement requests
  - ✓Urgent care visits
  - ✓Out of network services



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Medi-Cal Summary

- Grievances decreased by 1% from Q2 to Q3.
- Due to the identified grievance trends, American Logistics implemented the use of Lyft to provide timely pick-ups.
- Improvements to the provider directory were implemented for accuracy of the provider data in order to streamline Utilization Management's authorization process.
- Providers with a high volume of grievances took advantage of a provider coaching service, provided by CalOptima, as a means to improve their services.

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OneCare Connect Complaints

	Total Complaints	Member Appeals	Member Grievances	Membership
1Q-2018	282	55	227	15,031
2Q-2018	314	75	239	15,003
3Q-2018	336	101	235	14,944

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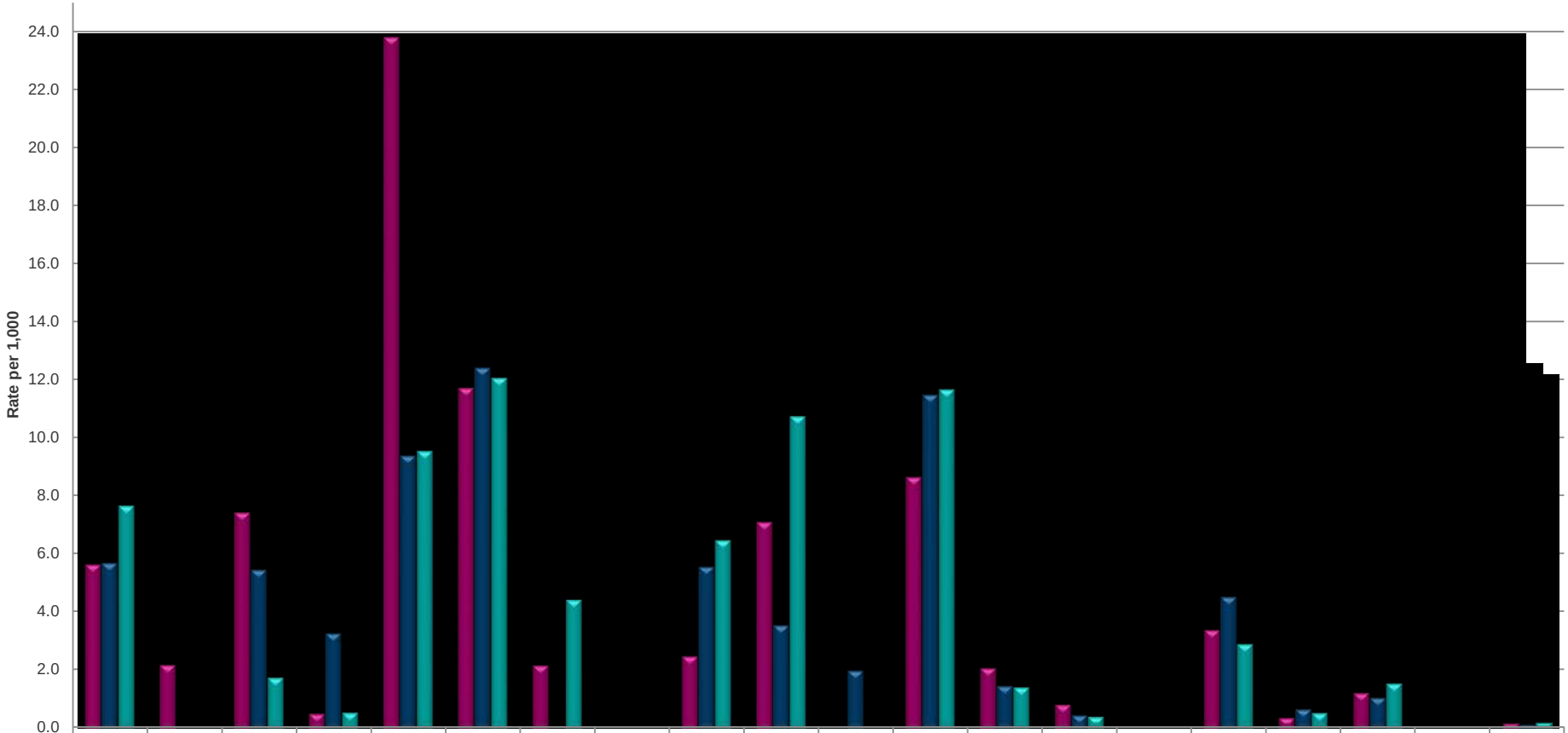
OneCare Connect Member Grievances Quarterly Rate/1,000



	Alta Med Health (522)	AMVI Care (425)	Arta (574)	Family Choice (1,808)	Heritage (210)	Monarch (4,813)	Noble (453)	OC Adv (62)	Prospect (2,628)	Talbert (1,118)	UCMG (496)	CCN (1,716)	OCC Prog (14,826)	OCC Pharmacy (14,826)	MLTSS (14,826)	American Logistics (19,695)	Behavioral Health (14,826)	Liberty Dental (14,826)	Silver and Fit (14,826)	VSP (14,826)
1Q-18 (227)	5.7	2.2	7.5	0.5	23.8	11.8	2.2	0.0	2.5	7.2	0.0	8.7	2.1	0.9	0.0	3.5	0.4	1.3	0.0	0.2
2Q-18 (239)	5.7	0.0	5.5	3.3	9.4	12.4	0.0	0.0	5.6	3.6	2.0	11.5	1.5	0.5	0.0	4.5	0.7	1.1	0.0	0.1
3Q-18 (235)	7.7	0.0	1.7	0.6	9.5	12.0	4.4	0.0	6.5	10.7	0.0	11.7	1.4	0.4	0.0	2.9	0.5	1.6	0.0	0.2

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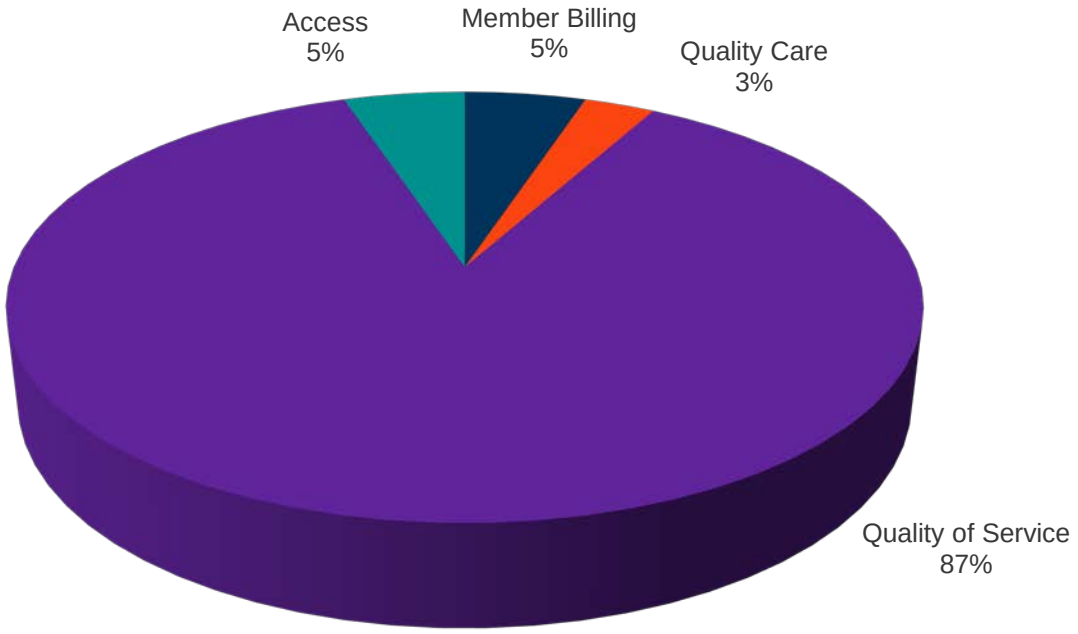
OneCare Connect Grievances by Category

- Quality of Service includes:
  - Delay in service
  - Dissatisfaction with Primary Care Provider (PCP) and staff



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OneCare Connect Summary

- Small decrease in grievances from Q2 2018 to Q3 2018.

- There was a unusual increase in Liberty Dental appeals related to crowns, root canals and dentures. This may be due to the supplemental dental benefit terminating at the end of 2018 and members being proactive before the benefit terminates.

- Regular meetings with American Logistics regarding Non-Medical Transportation concerns has reduced the volume of grievances.

OneCare Complaints

	Total Complaints	Member Appeals	Member Grievances	Membership
1Q-2018	16	4	12	1,325
2Q-2018	27	6	21	1,341
3Q-2018	20	7	13	1,365

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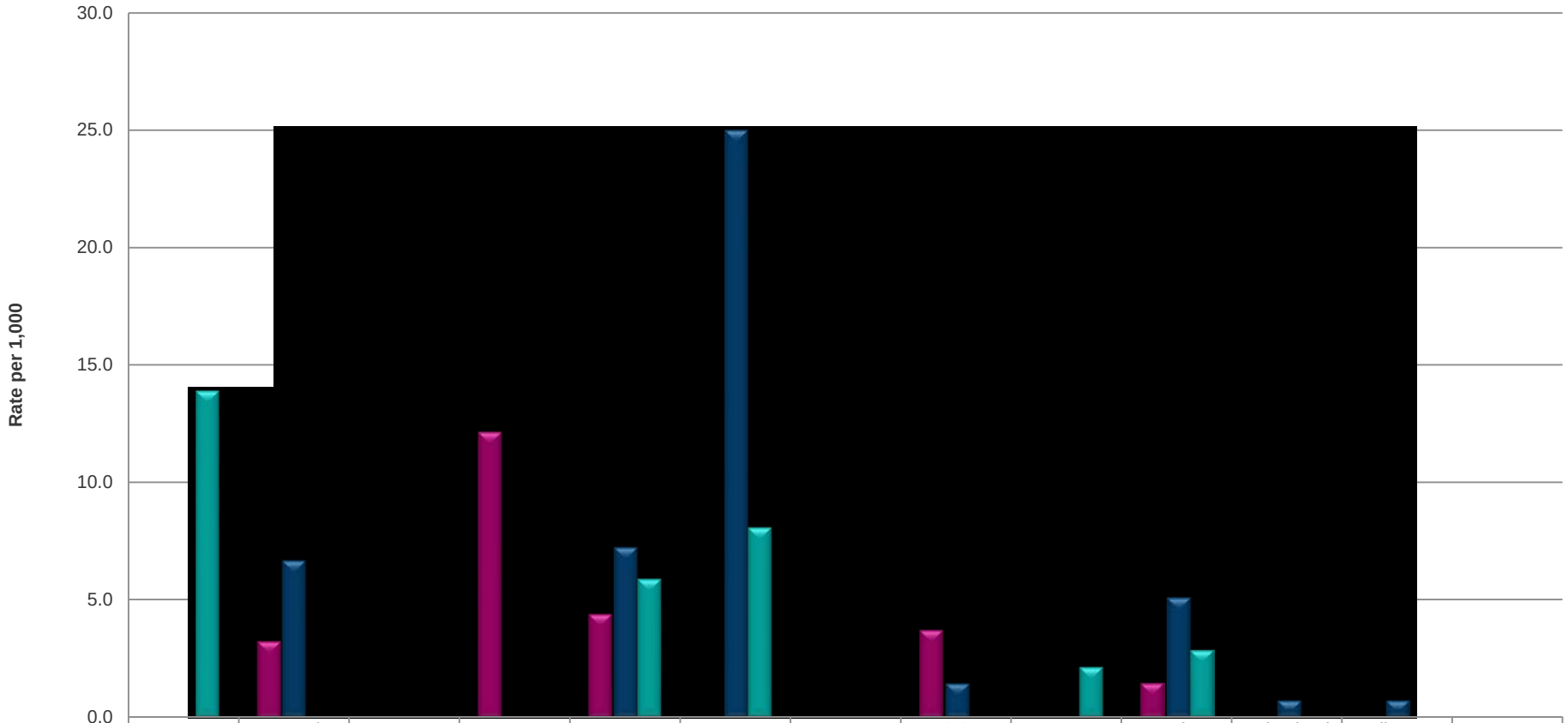
OneCare Member Grievances Quarterly Rate/1,000



	Alta Med Health (72)	AMVI/ Prospect (283)	Arta Western (93)	Family Choice (79)	Monarch (675)	Talbert (124)	UCMG (37)	OC Operations (1,383)	OC Pharm (1,383)	American Logistics (1,383)	Behavioral Health (1,383)	Liberty Dental (1,383)	VSP (1,383)
1Q-18 (12)	0.0	3.3	0.0	12.1	4.5	0.0	0.0	3.8	0.0	1.5	0.0	0.0	0.0
2Q-18 (21)	0.0	6.7	0.0	0.0	7.3	25.0	0.0	1.5	0.0	5.1	0.7	0.7	0.0
3Q-18 (13)	13.9	0.0	0.0	0.0	5.9	8.1	0.0	0.0	2.2	2.9	0.0	0.0	0.0

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OneCare Summary

- Grievances decreased from 21 in Q2 to 13 in Q3 and remain consistently low.

- Grievances were primarily service related as follows:
  - ✓ Providers not responding to medication requests
  - ✓ Dissatisfaction with transportation vendor
  - ✓ Rudeness

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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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