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Concurrent with the release of Gov. Newsom's fiscal year (FY) 2021–22 proposed budget, the Department of Health Care Services (DHCS) released a revised CalAIM proposal. CalAIM is a multiyear initiative designed to improve Medi-Cal members' quality of life and health outcomes by implementing delivery system, program and payment reforms.

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The proposal was initially released in late 2019, but put on hold due to the pandemic. The new proposal revitalizes the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) initiatives, calling for implementation on January 1, 2022.

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CalAIM's relaunch also brings the restart of some state-sponsored workgroups, with a plan to finalize requirements in the spring of 2021. CalOptima will participate in the state's stakeholder-feedback process and has begun local coordination efforts by initiating reoccurring meetings with Orange County Health Care Agency (HCA) that began January 22.

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Additionally, CalOptima will engage our advisory committees, health networks, provider associations, community collaboratives and others to ensure awareness of the significant elements in CalAIM.

Medi-Cal and COVID-19 Vaccine Q&A

With the recent federal approval of COVID-19 vaccines, the Department of Health Care Services (DHCS) is seeking federal approval to help support delivery of the vaccine to all Medi-Cal members. The vaccine will be provided at no cost to all Californians. The following series of questions and answers (Q & As) provides information regarding who is covered, how to get vaccinated and how DHCS plans to reimburse providers for the administration fee tied to the vaccine under Medi-Cal.

Who is covered to get vaccinated?

All full-scope Medi-Cal members are covered and will receive the vaccine at no cost. Coverage is also extended to people enrolled in restricted-scope Medi-Cal and the COVID-19 Uninsured Group Program, as well as the Family Planning, Access, Care and Treatment (FPACT) program. In Orange County, eligibility has been expanded to include all people age 65 and older, greatly extending access beyond the frontline health care workers and long-term care facility residents who got the first doses. Distribution will continue to expand until vaccines are available to everyone, which is estimated to be summer.

Where and when are vaccinations being administered?

California's plan for administering the vaccine is initially limited and split into phases. More details on those phases, including who is covered in each one, and on the vaccination roll-out in general, are available in the vaccination section of the California for All COVID-19 website at <https://covid19.ca.gov/vaccines/#When-can-I-get-vaccinated>. The California Department of Public Health (CDPH) is working with local agencies to distribute COVID-19 vaccines. Local health departments are identifying facilities that have the capacity to properly maintain the vaccine while meeting all federal and state requirements. Enrollment in the vaccine distribution program is limited at this time to providers authorized by their local health department. Others may enroll as vaccine supply increases.

Locally members may look to their providers for information about vaccine distribution which, given the current limited vaccine supply, is in phases that prioritize critical populations (to view the different phases, visit <https://coronavirus.egovoc.com/covid-19-vaccination-distribution>). Additionally, Orange County is using an online tool, www.othena.com, to help with vaccine prioritization and scheduling. CalOptima encourages you to be familiar with it to assist in answering questions from members.

Who do providers bill?

As the federal government will pay for the initial vaccines, there is no Medi-Cal provider reimbursement for the COVID-19 vaccine itself. Providers will bill for administration of the COVID-19 vaccine on medical, outpatient or pharmacy claims. DHCS will reimburse providers the vaccine administration for all covered Medi-Cal populations exclusively through the Medi-Cal Fee-for-Service (FFS) delivery system. This includes administration to individuals enrolled in Medi-Cal managed-care health plans.

What is the reimbursement rate that DHCS will pay

DHCS is seeking federal approval to pay all providers up to the Medicare rate for COVID-19 vaccinations, subject to Medi-Cal FFS policy. The maximum allowable rate for a single-dose vaccine is \$28.39; the maximum for a double-dose vaccine is \$16.94 for the initial dose and \$28.39 for the final dose (\$45.33 total).

What about Federally Qualified Health Centers (FQHCs), Rural Health Clinics, (RHCs) and Tribal Health Clinics (THCs)?

DDHCS will pay the applicable Prospective Payment System (PPS) under the all-inclusive rate (AIR), if the vaccination is administered during an in-person visit that meets the requirements of a billable office visit in the clinic setting. If the vaccine administration does not meet all of the requirements of a billable visit (e.g. only vaccine administration), the FQHC, RHC and THC can bill Medi-Cal FFS for administering the COVID-19 vaccine and be reimbursed the applicable dosage rate as noted above.

Other resources

There is more COVID-19 vaccine information on the DHCS website, including:

- Frequently Asked Questions (<https://www.dhcs.ca.gov/Documents/COVID-19/COVID-19-Vaccine-Administration-FAQs-122420.pdf>)
- COVID-19 vaccine administration letter to Medi-Cal managed care plans (<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-022.pdf>)
- The California for All COVID-19 website links to county COVID-19 websites (<https://covid19.ca.gov/get-local-information/>)

Member Rights and Responsibilities

As a CalOptima provider, you should be aware that our members have rights and responsibilities. These are the standards CalOptima promises members, as well as their responsibilities as members.

Members have a right to:

- Be treated with respect and dignity by all CalOptima, health network and provider staff
- Privacy and to have your medical information kept confidential
- Get information about CalOptima, our health networks, our providers, the services they provide and your member rights and responsibilities
- Choose a primary care provider (PCP) within CalOptima's network
- Talk openly with your health care providers about medically necessary treatment options, regardless of cost or benefit
- Help make decisions about your health care, including the right to say "no" to medical treatment
- Voice complaints or appeals, either verbally or in writing, about CalOptima or the care we provide
- Get oral interpretation services in the language that you understand
- Make an advance directive
- Ask for a State Hearing, including information on the conditions under which your State Hearing can be expedited
- Access family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and emergency services outside CalOptima's network
- Have access to your medical record and, where legally appropriate, get copies of, update or correct your medical record
- Access minor consent services
- Get written member information in large-size print and other formats upon request and in a timely manner appropriate for the format being requested
- Be free from any form of control or limitation used as a means of pressure, punishment, convenience or revenge
- Get information about your medical condition and treatment plan options in a way that is easy to understand
- Make suggestions to CalOptima about your member rights and responsibilities
- Freely use these rights without negatively affecting how you are treated by CalOptima, providers or the state

Members are responsible for:

- Knowing, understanding and following your member handbook
- Understanding your medical needs and working with your health care providers to create your treatment plan
- Following the treatment plan you agreed to with your health care providers

CalOptima Disease Management (DM) Programs

CalOptima designs its disease management (DM) programs to support the patient-provider relationship and equip members with the knowledge, skills and tools they need to effectively manage their health between medical office visits. Our goals are to help each member attain optimal self-management and, therefore, avoid unnecessary emergency room or hospital visits, reduce the risk of adverse events, and improve quality of life and health outcomes. The CalOptima disease management programs aim to support the member and keep the entire care team, especially the providers, involved in their personal care plans.

Programs available for Medi-Cal members:

Adult Diabetes — 18 years and older
Childhood Asthma — 3–18 years old
Adult Asthma — 19 years and older

Programs available for OneCare and OneCare Connect members:

Adult Diabetes — 18 years and older
Adult Asthma — 19 years and older
Congestive Heart Failure — 18 years and older

Identification: Program participants are identified monthly through claims, encounter and pharmacy data or through program referrals from members, health networks, providers or the CalOptima Health Education department. Eligible DM members receive a risk or acuity level, based on a risk stratification methodology and are re-assessed on a monthly basis.

Exclusions: Members with dementia or residing in a long-term care facility.

Risk Stratification: CalOptima stratifies program participants into high-risk and low-risk categories. Risk level is determined through points assigned to factors such as, but not limited to, past hospitalizations, ED visits and co-morbid conditions.

Member interventions:

Low and High-Risk Members: Newly identified low-risk and high-risk members enrolled in the program receive an introductory letter about the program and a condition-specific self-management handbook. In addition, members receive newsletters mailed directly to them several times a year (Asthma Aware, Diabetes Talk, Heart Health). Members also receive information on community classes and support for smoking cessation and other relevant wellness resources.

High-Risk Members: High-risk members enrolled in the program receive additional services. Upon identifying members who need outreach, our team of health coaches engage telephonically with high-risk members who have severe symptoms or complications. After conducting a thorough assessment, health coaches educate and support members and promote sustaining self-management behavioral change, adherence to treatment plans for their chronic conditions and encourage active engagement and communication with the care team. The health coach and member create a care plan which is regularly updated as goals change. The care plan is sent to both the member and his/her primary care provider (PCP). High risk members may receive additional resources such as face-to-face visits or self-monitoring devices for tracking symptoms.

To complete the Disability Awareness training, visit the CalOptima website at:
<https://www.caloptima.org/en/ForProviders/ProviderTrainings/DisabilityAwareness.aspx>.

Depression Screening: If the member screens positive on the depression screening tool (KADS-6 for pediatric members and PHQ-2 for adults), the health coach will inform the member's PCP. The member will be guided on how to self-refer to CalOptima's Behavioral Health department for further screening.

Provider resources:

Continuing Medical Education opportunities throughout the year regarding relevant topics on management of chronic conditions.

Resources and Tools for patient education and management.

Disease Management Referral Form is found on the CalOptima website at <https://www.caloptima.org/en/ForProviders/Resources/CommonForms.aspx> To refer a member, or for any questions about a program or currently enrolled member, complete the Disease Management Referral Form and fax to **714-338-3127**, or email to healthpromotions@caloptima.org. If you have any questions, call CalOptima's Health Education and Disease Management department at **714-246-8895**.

Provider Training

Please be aware that the Department of Health Care Services (DHCS), requires CalOptima to ensure that all providers receive training regarding the Medi-Cal managed care program in order to operate in full compliance with our contract and all applicable federal and state statues and regulations.

CalOptima shall also ensure that provider training relates to Medi-Cal managed care services, policies, procedures and any modification to existing services, policies or procedures.

CalOptima is required to conduct training for all providers no later than 10 working days after CalOptima places a newly contracted provider on active status and shall complete the training within 30 calendar days of placing on active status.

CalOptima must ensure that provider training includes, but is not limited to, information on all member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and the right to actively participate in health care decisions. CalOptima shall ensure that ongoing training is conducted when deemed necessary by either CalOptima or DHCS.

CalOptima shall develop and implement a process to provide information to providers and to train providers on a continuing basis regarding clinical protocols and evidence-based practice guidelines and DHCS developed cultural awareness and sensitivity instruction for seniors and persons with disabilities. This process shall include an educational program for providers regarding health needs specific to this population that utilizes a variety of educational strategies including, but not limited to, posting information on websites as well as other methods of educational outreach to providers.



Initial Health Assessment (IHA) Tips

The IHA is completed with his or her primary care provider, appropriate medical specialist, or non-physician medical provider during the member's initial visit. Newly enrolled patients, including those with disabilities, must receive their IHA within 120-days of enrollment, and in a culturally and linguistically appropriate manner. The purpose of the IHA is to assess and set the baseline for managing health needs of our members.

The IHA should include the following elements:

Comprehensive History

Which includes, but is not limited to:

- Member's history of present illness
- Member's past medical history
- Member's social history
- Review of the member's organ systems

Preventive Services for Asymptomatic Members

Age under 21:

Age-specific assessments and services required by the Child Health and Disability Prevention Program (CHDP), as specified by the American Academy of Pediatrics (AAP)
Assessments that follow the AAP periodicity schedule for examinations occurring more frequently than allowed under the CHDP schedule

Age 21 and older:

Preventive screening, testing and counseling in accordance with the Guide of Clinical Preventive Services of the U.S. Preventive Services Task Force

Perinatal Services:

Perinatal services in accordance with guidelines of the American Congress of Obstetricians and Gynecologists (ACOG)

Comprehensive Physical

Which includes a mental health status exam

Diagnoses and Plan of Care

This should include follow-up activities as well

An Individual Health Education Behavioral Assessment (IHEBA)

The provider should administer the IHEBA utilizing the Staying Healthy Assessment (SHA) or other tool approved by CalOptima and the Department of Health Care Services (DHCS)

When Does a “No Prior Authorization Required” Really Require a Prior Authorization?

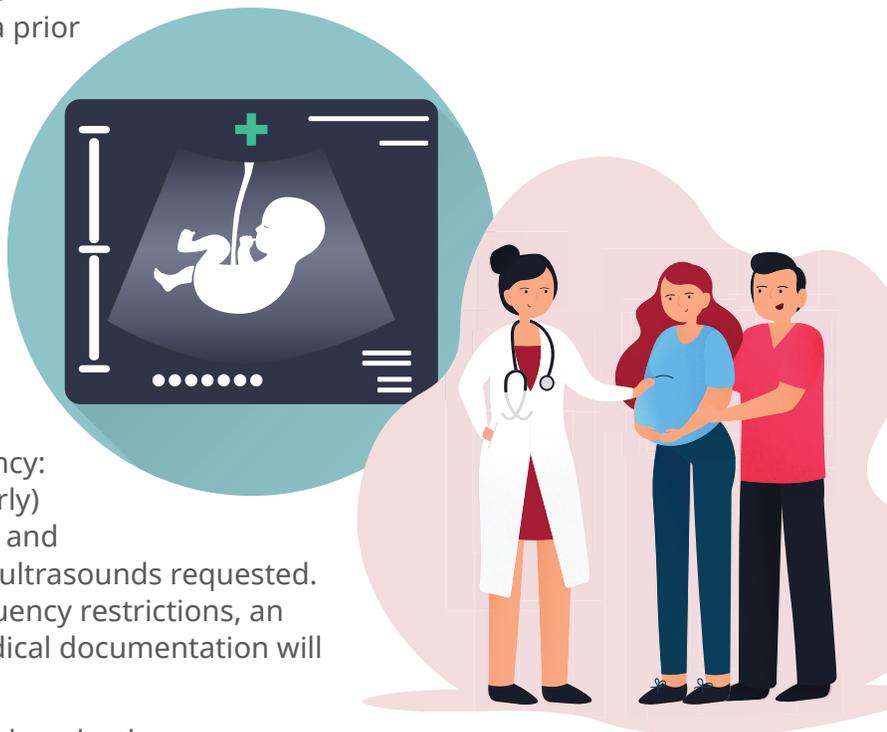
Recently there has been some confusion regarding coding and frequency of services, and whether they do or do not require authorization. Any requested service that is in excess of the Medi-Cal allowable frequency or quantity as indicated in the **Medi-Cal manual**, requires an authorization. Providers should verify with their individual health networks the policies and requirements regarding prior authorizations.

The following are examples of when a “No Prior Authorization Required” actually does require a prior authorization:

Ultrasound during pregnancy.

Ultrasound performed for routine screening during pregnancy is considered an integral part of patient care and its reimbursement is included in the obstetrical fee. Ultrasound during pregnancy is reimbursable only when used for the diagnosis or treatment of specific medical conditions.

- Medi-Cal Provider Manual Part 2 — Pregnancy: Early Care and Diagnostic Services (preg early) shows the diagnosis restrictions, frequency and documentation guidelines required for the ultrasounds requested. If the quantities requested exceed the frequency restrictions, an authorization request, with supporting medical documentation will be required.
- 76815: has a frequency limit of once in 180 days, by the same provider. Additional claims may be reimbursed if documentation justifies medical necessity — additional ultrasound would require prior authorization.



NOTE: See the Pregnancy: Early Care and Diagnostic Services (preg early) for the most current list of codes, frequency limits and documentation at: <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/pregearly.pdf>.

Another example — Durable Medical equipment

- Medi-Cal Provider Manual Part 2 — Durable Medical Equipment (DME) Billing Codes: Frequency Limits (dura cd fre) includes a list of DME codes and the frequency restrictions that apply to each code.
- Many of the codes indicated on this list do not usually require prior authorization, but if the request exceeds the frequency limit, it will, e.g., as canes that do not usually require prior authorization, would require prior authorization, if requested earlier than once every 5 years.
- E0100 (Cane) — 1 in 5 years
- E0105 (Cane, quad or three prong) 1 in 5 years

NOTE: See Durable Medical Equipment (DME) Billing Codes: Frequency Limits for the most current list of codes and frequency limits at: <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duracdfre.pdf>.

Access and Availability Standards

Every year, CalOptima analyzes our providers' performance of access and availability against the standards set forth in CalOptima policy #GG.1600 displayed below.

Standards for access to covered services

Service Type	Standard Procedure
Emergency Services	<ul style="list-style-type: none"> Emergency services shall be available immediately to members 24 hours a day, seven days a week.
Urgent Care Services	<ul style="list-style-type: none"> Urgent care services shall be made available to a member within 24 hours after date of request.
Urgent Care Appointments at Primary Care Provider Office	<ul style="list-style-type: none"> Urgent appointment for services that do not require prior authorization shall be available within 48 hours after the request. Urgent appointment services that require a prior authorization shall be available within 96 hours after date of request.
Non-Urgent Services	<ul style="list-style-type: none"> Non-urgent acute care services shall be available to a member within three business days after date of request. Non-urgent primary care services shall be available to members within 10 business days after date of request.* Routine physical exams and health assessments shall be available to a member within 30 days after date of request. Non-urgent specialty care shall be available to a member within fifteen 15 days after date of request.
Prenatal Care First Visit	<ul style="list-style-type: none"> Appointments for the first prenatal visit shall be available to a member within 10 business days after date of request.
Telephone Access During Business Hours	<ul style="list-style-type: none"> <i>Non-urgent and non-emergency messages during business hours:</i> A provider shall return the call within 24 hours after the time of message. <i>Urgent message during business hours:</i> A provider shall return the call within 30 minutes after the time of message. <i>Emergency message during business hours:</i> All members shall be referred to the nearest emergency room. Recorded message should include the following: "If you feel that this is an emergency, hang up and dial 911"
Telephone Access After Hours	<ul style="list-style-type: none"> A primary care provider (PCP) or his or her designee, or an appropriate licensed professional under his or her supervision, shall be available 24 hours a day, seven days a week, to respond to member calls after hours or to a hospital emergency room provider. If live attendant answers and the call is an emergency, the attendant shall refer the member to 911 emergency services or instruct the member to go to the nearest emergency room. If using a recorded message, it should include the following: "If you feel that this is an emergency, hang up and dial 911 or go to the nearest emergency room."

**A provider may offer an appointment for non-urgent primary care within the same or next business day from the time the member requests the appointment, and advance scheduling of an appointment at a later date if the member prefers not to accept the appointment offered within the same or next business day.*

The Quality Analytics department will coordinate performance reviews to gauge adherence to access and availability standards. For a complete list of Access and Availability Standards or additional information, call the Provider Resource Line at **714-246-8600**.

HEDIS Measurement Year (MY) 2020 Training

CalOptima is required to report Healthcare Effectiveness Data and Information Set (HEDIS) rates to the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS).

As part of this annual reporting requirement, a medical record review is allowed for a subset of measures known as **Hybrid Measures**. As a contracted CalOptima provider, we recognize that you play a vital role in promoting good health to our members. That is why CalOptima has developed a set of online training modules, each containing annual content to help providers understand the measures specifications and required documentation to meet compliance for each measure.

In addition to having four modules instead of six, the following are the changes made for HEDIS MY2020:

- **Naming convention for HEDIS (updated)**
- **Measures and sub-indicators (retired for HEDIS MY 2020)**
- **Timeline for HEDIS specs publication (updated)**
- **Reporting methodology (updated for three of the hybrid measures)**



The HEDIS Training Modules for MY2020 are located on the CalOptima website at <https://www.caloptima.org/en/ForProviders/ProviderTrainings/HEDISHybridMedicalRecordReview.aspx>.

We encourage you to review all the modules and share the information with your office staff. If you have questions or need assistance, email CalOptima at **HEDISMailBox@CalOpitma.org**.

Frequently Asked Questions About Utilization Management (UM) Decision Making



How are UM decisions made?

At CalOptima, we make our decisions to authorize, modify or deny health care services based upon medical necessity and Medi-Cal coverage. We do not reward our staff or providers if they do not approve services, and there are no financial incentives associated with these decisions. Decisions to deny or modify your request, based on medical necessity, can only be made by another physician or, in the case of a pharmacy request, by a licensed pharmacist.

What criteria and/or guidelines are used to make decisions?

We use nationally recognized guidelines, such as MCG, InterQual, the Medi-Cal Manual, and various guidelines from recognized professional academies like the American Academy of Family Physicians and the American Congress of Obstetricians and Gynecologists. Guidelines and criteria sets are based on sound clinical principles and processes. They are reviewed and updated as required on an annual basis. To ensure consistency with current standards of care and local practice, we involve actively participating practitioners in the development and approval of criteria.

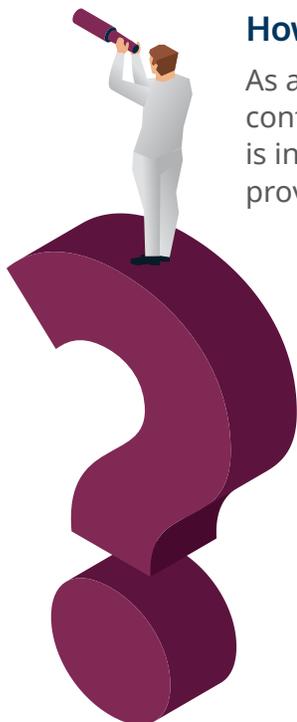
How can I obtain a copy of the criteria used in making a decision?

As a CalOptima provider, you have the right to ask about our UM decisions. You can contact our medical director in writing or via telephone. His or her telephone number is included in the Notice of Action letter you received. CalOptima Community Network providers may call **714-246-8600** to request criteria.

What if I have a general question about the UM process?

UM staff is available during CalOptima business hours from 8 a.m. to 5:30 p.m. for inbound calls regarding UM issues. After-hours contact with the UM staff is through the on-call service, which will notify staff to contact you. You can reach the UM staff by calling CalOptima's Utilization Management department at **714-246-8686**.

To learn how UM decisions are made for your practice, providers should contact their individual health network's Provider Relations department. CalOptima Community Network providers may call **714-246-8600**.



CMS Monitoring and Compliance of Encounter Data, Performance Metrics and Thresholds

On August 20, 2018, the Centers for Medicare & Medicaid Services (CMS) released a Health Plan Management System (HPMS) memo, "Monitoring and Compliance of Encounter Data", which finalizes the encounter data performance metrics and thresholds. This memorandum discusses seven performance metrics and their respective thresholds for Medicare Advantage plans encounter data. The thresholds, listed in the attached table, are designed to identify performance issues that are substantially below reasonable expectations for submissions.

You may review the guidance for creating and submitting encounter data records (EDRs) and chart review records (CRRs) that comply with guidance from CMS by visiting <https://www.hhs.gov/guidance/document/encounter-data-submission-and-processing-guide-1>.

Medicare advantage encounter data performance measures and thresholds

Performance Metric	Performance Threshold (measured at contract level)
O1: Failure to Complete End-to-end Testing and Certification	Failure to complete end-to-end testing and certification for a contract within 4 months of the beginning of operations.
O2: Failure to Submit Any Accepted Records to the Encounter Data System	No accepted records submitted during the calendar year.
O3: Excessive Submission of Encounter Data Records at End of Risk Adjustment Submission Window	27% percent or more of encounter data and chart review records for the applicable calendar year were submitted in the last 2 months before the risk adjustment deadline. The purpose of this evaluation is to ensure that CMS systems are not overloaded and that plans are regularly submitting data over time
C1: Extremely Low Volume of Overall Encounter Data Records	The number of encounter data records per enrollee is below the threshold. The threshold is the lower bound, using an 80% confidence interval around the mean number of records per enrollee, within each peer group. Contracts are categorized into three different peer groups based on contract types: Medicare Medical Savings Accounts (MSAs), local or regional Preferred Provider Organizations (PPOs) and Private Fee-for-Service (PFFS).
C2: Extremely Low Volume of Inpatient Encounter Data Records	The number of enrollees with an accepted inpatient record in encounter data system (EDS) falls at or below 40% of the number of enrollees with an inpatient risk adjustment processing system (RAPS) record. For example, if beneficiary A has an inpatient record in RAPS, then beneficiary A should also have at least 1 inpatient record accepted in EDS. If a contract has 100 beneficiaries for whom there is at least 1 inpatient RAPS record and fewer than 40 of those enrollees have an accepted inpatient record in EDS, then the contract would not meet the performance threshold.
C3: Extremely Low Volume of Professional Encounter Data Records	The number of enrollees with an accepted professional record in EDS falls at or below 90% of the number of enrollees with a professional RAPS record.
C4: Extremely Low Volume of Outpatient Encounter Data Records	The number of enrollees with an outpatient record in EDS falls at or below 70% of the number of enrollees with an outpatient RAPS record.

Tips For Working With Interpreters

Medical appointments that include assistance from an interpreter, have different dynamics than appointments performed without assistance of an interpreter. Below are some recommended tips for how to work with interpreters.

- **If possible, choose an interpreter whose age, gender and background are similar to the patient.** A patient might be reluctant to disclose uncomfortable information, for example, in front of an interpreter of a different gender.
- **Hold a brief meeting with the interpreter, if needed.** If it is your first time working with a professional interpreter, briefly meet with the interpreter first to agree on basic interpretation protocols. Let the interpreter brief the patient on the interpreter's role.
- **Allow enough time for the interpreted sessions.** Remember that an interpreted conversation requires more time. What can be said in a few words in one language may require a lengthy paraphrase in another.
- **Read body language during face-to-face encounters.** Making eye contact is key to the provider-patient relationship. Arrange yourself so that you, the patient, and the interpreter are visible to one another (i.e., triangular). Watch the patient's eyes and facial expression when you speak and when the interpreter speaks. Look for signs of comprehension, confusion, agreement or disagreement.
- **Speak in a normal voice, clearly, and not too fast or too loudly.** It is usually easier for the interpreter to understand speech produced at normal speed and with normal rhythms, than artificially slow speech.
- **Avoid jargon and technical terms.** Avoid idioms, technical words or cultural references that might be difficult to interpret. (Some concepts may be easy for the interpreter to understand but extremely difficult to interpret.)
- **Talk to the patient directly, using first person.** Be brief, explicit and basic. Remember that you are communicating with the patient through an interpreter. Pause after a full thought for the interpretation to be accurate and complete. If you speak too long, the interpreter may not remember to include everything you say.
- **Don't ask or say anything that you don't want the patient to hear.** Expect everything you say to be interpreted, as well as everything the patient and his or her family says.
- **Be patient and avoid interrupting during interpretation.** Allow the interpreter as much time as necessary to ask questions, for repeats and for clarification. Be prepared to repeat yourself in different words if your message is not understood. Professional interpreters do not interpret word-for-word but rather concept-by-concept. Also remember that English is a direct language and may need to be relayed in complex grammar and different communication patterns.
- **Be sensitive to appropriate communication standards.** Different cultures have different protocols to discuss sensitive topics and to address physicians. Many ideas common in the United States may not exist in the patient's culture and may need detailed explanation in another language.

*Source: Tips for Working with Interpreters, Section N9 CalOptima 2019 Provider Manual, www.caloptima.org.

Updating Your Provider Directory Listing

All providers are required to submit accurate and timely updates of changes to demographic and other information required, for inclusion in the CalOptima provider directory. This is a California State law, which was established with Senate Bill 137 (SB137).

This law underscores the importance of ensuring a provider's information, such as whether or not you are accepting new patients, are up-to-date, and any changes are communicated to the provider's contracted health network in a timely manner. Specifically, the law requires: The listing of all contracted health networks and services of the provider or provider group.

Providers to notify the provider's contracted health network within five business days if they are no longer accepting new patients or if they were not accepting new patients and are now open to new patients.

Providers who are not accepting new patients, and are contacted by a new patient, to direct the patient to their health network to find a provider and to report the directory inaccuracy.

Providers to be responsive to the provider's contracted health network's notifications regarding the accuracy of information in the provider directory by either confirming the information is correct or updating information as appropriate.

Failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p) of SB137. Providers have 30 business days to confirm with the provider's contracted health network their information is either current and accurate or requires updates. If no response, CalOptima shall take no more than 15 business days to verify whether the provider's information is correct or requires updates.

If CalOptima is unable to verify the provider's information is correct or requires updates, CalOptima will notify the provider 10 business days in advance that they will be removed from the provider directory or directories at the next required update. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business day notice period.



To keep your CalOptima provider directory listing up to date, contact your health network's Provider Relations department. CalOptima Community Network providers may call 714-246-8600.

DHCS Women's Preventive Health QI Postcard Addressing BCS and CCS Screenings

The Department of Health Care Services (DHCS) is sharing its 10th in a series of brief Quality Improvement (QI) "Postcards". The Women's Preventive Health Quality Improvement (QI) Postcard contains information addressing Breast and Cervical Cancer screenings.

Additionally, the postcard highlights the effects of the COVID-19 pandemic on the utilization of the screenings, various disparities and barriers aiding in the decline of screenings. Providers are encouraged to engage with members, to inform them of the importance of these preventive services through a variety of tools.

To view the above recommendations online and to access information links, visit https://www.caloptima.org/~media/Files/CalOptimaOrg/508/COVID19/2021-01-19_WomensHealthQIPostcard_508.ashx



RECOMMENDATIONS DURING COVID-19

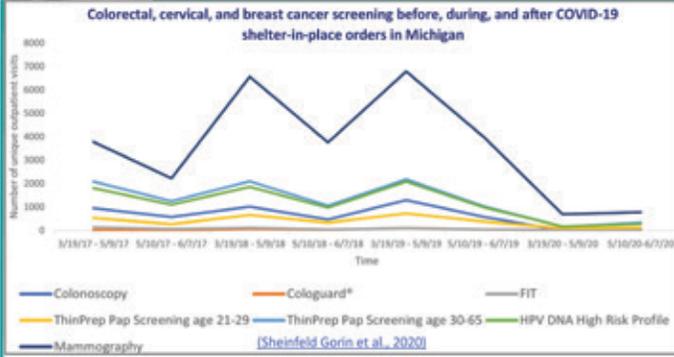
ADDRESSING BCS AND CCS SCREENINGS



The dramatic reductions in cancer screening [due to the COVID-19 pandemic] have created considerable challenges for cancer detection, with later stages of disease at the time of diagnosis, increased cancer incidence (particularly for cervical and colorectal cancer), and greater morbidity and mortality.

[American Cancer Society](#)

Colorectal, cervical, and breast cancer screening before, during, and after COVID-19 shelter-in-place orders in Michigan



Number of average breast cancer tests

Time

— Colonoscopy — Cologuard® — FIT
— ThinPrep Pap Screening age 21-29 — ThinPrep Pap Screening age 30-65 — HPV DNA High Risk Profile

[Sheinfeld Gorin et al., 2020]

"NCI estimates a drop of 75% in mammograms since March...An NCI model looking at just breast cancer and colorectal cancer predicts there will be 10,000 excess deaths in the U.S. over the next 10 years because of pandemic-related delays in diagnosing and treating these tumors." [Sharpless, 2020]

DISPARITIES AND BARRIERS IN SCREENING

- ▶ [Lack of regular contact](#) with a primary health provider
- ▶ [Decreased perceived risk](#) of having breast cancer
- ▶ [Mammography usage is not equal](#) among different populations
- ▶ [Prolonged delays in screening](#) will elevate the cancer disparity in minority populations
- ▶ [Fear of COVID-19 exposure](#) hinders use of preventive services

MCP AND PROVIDER RESOURCES FOR BCS AND CCS

- ▶ Efforts to [promote breast cancer screening](#) and overcome barriers for [populations](#) with low screening prevalence
- ▶ Utilize organizations that contract with [Community Health Workers](#), [Community Health Partners](#) and [Patient Navigators](#)
- ▶ [Culturally tailored educational interventions](#) may increase attendance at breast and cervical cancer screening among ethnic minority women
- ▶ Collaboration with [mobile mammography vans](#) to meet members in their communities



RECOMMENDATIONS DURING COVID-19

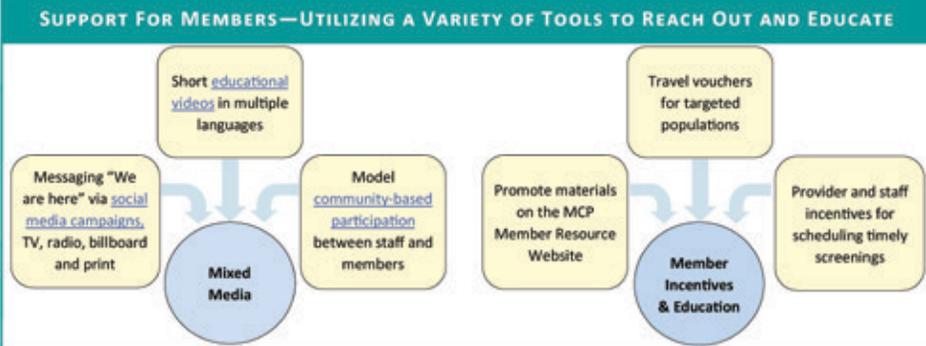
ADDRESSING BCS AND CCS SCREENINGS



The dramatic reductions in cancer screening [due to the COVID-19 pandemic] have created considerable challenges for cancer detection, with later stages of disease at the time of diagnosis, increased cancer incidence (particularly for cervical and colorectal cancer), and greater morbidity and mortality.

[American Cancer Society](#)

SUPPORT FOR MEMBERS—UTILIZING A VARIETY OF TOOLS TO REACH OUT AND EDUCATE



MCP PRACTICES—Supporting Providers and Members During COVID-19



Promote Women's Health Day to address BCS, CCS and Care Gap Clinics with access to multiple preventive services



Provide culturally appropriate, population focused mobile mammography



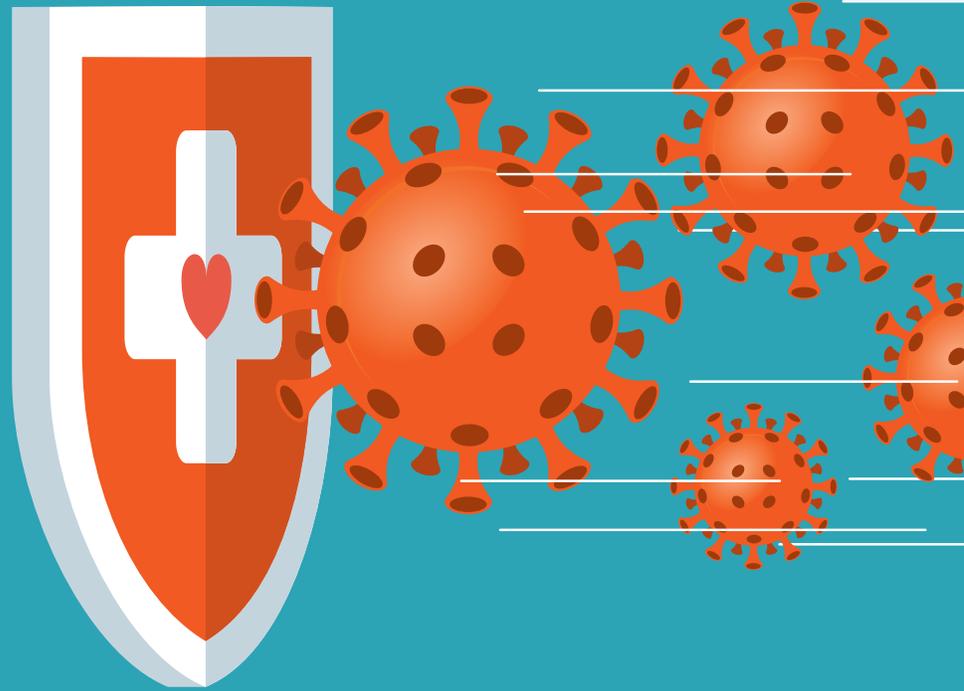
Geo-mapping by zip code to identify screening care gap hotspots



Utilize Neighborhood Patient Navigators to handle outreach and help members address barriers to care

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PROTECT YOURSELF FROM COVID-19



Getting vaccinated is
SAFE and **EFFECTIVE**

If you live or work in Orange County you can register at othena.com to be notified when you are eligible to sign up for the COVID-19 vaccine.



A Public Agency

CalOptima
Better. Together.

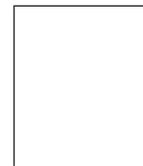
caloptima.org

  @caloptima

CalOptima Meeting Information

Unless otherwise specified, all meetings are held virtually at this time due to COVID-19. To select which virtual meeting you would like to attend, visit the CalOptima website at:

<https://www.caloptima.org/en/About/BoardAndCommitteeMeetings.aspx>. For more information, please call **714-246-8600**.



P.O. Box 11063
Orange, CA 92856-8163

CalOptima Board of Directors*

2 p.m.

- March 4, 2021
- April 1, 2021
- May 6, 2021
- June 3, 2021

CalOptima Board of Directors' Finance and Audit Committee*

2 p.m.

- February 18, 2021
- February 17, 2021
- May 20, 2021
- May 19, 2021

CalOptima Board of Directors' Quality Assurance Committee*

5:30 p.m.

- February 17, 2021
- May 19, 2021

Investment Advisory Committee

3 p.m.

- April 23, 2021

Member Advisory Committee (MAC)*

2:30 p.m.

- February 11, 2021
- April 8, 2021
- June 10, 2021

OneCare Connect Member Advisory Committee (OCC MAC)*

3 p.m.

- February 25, 2021
- April 22, 2021
- June 24, 2021

Provider Advisory Committee (PAC)*

3 p.m.

- February 11, 2021
- March 11, 2021
- April 8, 2021
- May 13, 2021
- June 10, 2021

Whole-Child Model Family Advisory Committee (WCMFAC)*

9:30 a.m.

- February 23, 2021
- April 27, 2021
- June 22, 2021

**Public meeting*

Annual Provider Training:

Cultural Competency

To ensure that our providers receive the resources and training necessary to deliver quality care to our members, CalOptima developed the **Cultural Competency Annual Training**. This training is designed to help our providers identify the diverse values and beliefs of our members, while understanding how culture and language may influence the health of the populations we serve.

To help you become more culturally and linguistically competent in providing care to CalOptima members, visit <https://www.caloptima.org/en/ForProviders/ProviderTrainings/CulturalCompetencyTraining.aspx>.

Blood Lead Screening

CalOptima has developed the **Blood Lead Screening Training** to promote the accurate coding and inclusion of all blood lead screening tests in annual health screening data, in accordance with the California Code of Regulations (CCR).

In addition, CalOptima providers are required to report blood lead screening test results to the California Department of Public Health (CDPH) Childhood Lead Poisoning Prevention Branch (CLPPB).

Providers will complete this training as part of their initial onboarding and annual training requirement. To view the **Provider Initial Onboarding and Annual Training** modules, visit the CalOptima website at: <https://www.caloptima.org/en/ForProviders/ProviderTrainings/ProviderOnboarding.aspx>

Visit Our Website

Visit CalOptima's website at www.caloptima.org to view provider manuals and information on the following topics:

- Member Rights and Responsibilities
- QI Program and Goals
- Privacy and Confidentiality
- Pharmaceutical Management Procedures
- Clinical Practice Guidelines
- Complex Case Management
- Disease Management Services
- Utilization Management

To request hard copies of this information, please call **714-246-8600**.