# PROVIDER PRESS NEWSLETTER

CalOptima
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FALL 2021

TOP NEWS INSIDE

**NCQA Rates CalOptima Among Best Medi-Cal Plans in California**



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## Encourage Patients to Vaccinate Against the Flu

COVID-19 mitigation measures like mask wearing, staying home, hand washing, school closures, reduced travel, increased ventilation of indoor space and physical distancing likely contributed to the low level of flu activity during the 2020–21 season. As more people roll back these COVID-19 precautions, it's more important than ever to encourage your patients to get the flu vaccine. Remember to schedule flu shot appointments for all your patients 6 months of age and older.

### Vaccine tips:

- The flu vaccine is needed every year to protect children, seniors and high-risk patients. It is administered at no cost to CalOptima members.
- Providers are the most trusted source of vaccine information and advice.
- Every visit with a patient is an opportunity to recommend the flu vaccine or to vaccinate.
- Call patients or send email and text reminders to get the flu vaccine.
- The flu vaccine can be administered simultaneously with or any time before or after administration of the currently available COVID-19 vaccines.

CalOptima promotes the importance of annual flu vaccination to members through member newsletters, social media campaigns and targeted mailings. Thank you for your continued support in providing quality health care services to our members. Please visit https://www.caloptima.org/en/ForProviders/Resources/HealthEducation.aspx for additional member health education.

# NCQA Rates CalOptima Among Best Medi-Cal Plans in California

For the first time since the pandemic began, the National Committee for Quality Assurance (NCQA) released its national health plan ratings, naming CalOptima one of the top Medi-Cal health plans in California. This is the seventh year in a row that CalOptima has earned recognition for leadership in quality.

CalOptima received a rating of 4 out of 5 in NCQA's Medicaid Health Plan Ratings 2021. No other Medi-Cal plan in California earned higher than 4 out of 5. Only 16 Medicaid plans of the 185 reviewed nationwide scored higher. The NCQA ratings are based on standardized, audited data regarding clinical performance and member satisfaction.


Medi-Cal
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"CalOptima's seven-year record of outstanding quality is based on a commitment to provide our members with access to the best care possible," said Supervisor Andrew Do, Chair of the CalOptima Board of Directors and Chairman of the Orange County Board of Supervisors. "Throughout the pandemic, CalOptima has strengthened engagement with community stakeholders and supported our members' diverse and comprehensive needs."

NCQA assesses Medicaid plan quality based on 39 clinical measures related to both preventive care and treatments. Preventive measures report whether members get services to keep them healthy, such as well-child visits, immunizations and nutrition counseling. Treatment measures gauge whether members receive appropriate care in response to illnesses and chronic diseases, including diabetes and high blood pressure. NCQA also evaluates a plan based on seven customer satisfaction dimensions, such as getting care quickly and how well doctors communicate.

The rating achievement comes on the heels of NCQA's renewal of CalOptima's Medi-Cal accreditation for three years, through July 27, 2024. Accreditation means that health plan operations meet rigorous requirements for consumer protection and quality improvement. CalOptima received 100% of the allowable points on its renewal review.

"Conscientious performance drives CalOptima's top performance. Therefore, we thank the thousands of Orange County doctors and nurses for consistently delivering quality care to our members," said Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer. "CalOptima shares this honor with the frontline providers who continually demonstrate their dedication to the vulnerable Medi-Cal population."

# Toolkit Provides Resources for Annual Wellness Visit

Due to the ongoing COVID-19 pandemic, some members may have been unwilling or unable to visit their health care provider, missing needed care or preventive screenings. Because of these circumstances, a member's annual wellness visit has taken on increased importance. This Medicare-covered visit is an important opportunity for providers to promote wellness and detect health risks early. The visit is not a physical exam, but a chance for members to talk with providers about their overall health. Medicare covers a number of preventive services for health concerns that could be identified during the annual wellness visit. During these visits, members and providers create or update a personal prevention plan, which is designed to prevent or detect illness based on an individual member's health and risk factors. The annual wellness visit includes things such as:

- Assessing health risks
- Reviewing medical and family history
- Developing/updating a list of current providers and prescriptions
- Checking routine measurements, such as height, weight and blood pressure
- Screening for cognitive impairment, fall risk, depression and substance use
- Creating a schedule of needed preventive services (screenings and vaccinations)

To promote utilization of annual wellness visits, the Orange County Healthy Aging Initiative developed the Annual Wellness Visit Toolkit for provider use. The toolkit is a comprehensive collection of resources to help providers perform the annual wellness visit. Included in it are:

- A mailer template to remind members of their annual wellness visit
- A sample Health Risk Assessment members can fill out prior to their appointment
- Resources to assist in screening for cognitive impairment, fall risk, depression and substance use
- Templates for creating personal prevention plans
- Health education materials for members
- Resources to refer members for additional health needs

Members become eligible for an annual wellness visit after an initial 12-month enrollment with Part B coverage. Providers should verify a member's eligibility for an annual wellness visit to ensure reimbursement and use billing code G0438 for an initial visit and G0439 for subsequent visits.

To access the contents of the Annual Wellness Visit Toolkit, as well as watch a video about the toolkit and annual wellness visits, visit the Orange County Aging Services Collaborative's website: http://www.ocagingservicescollaborative.org/annual-wellness-visit-toolkit.

# What's the Latest With CalAIM?

On January 1, 2022, CalOptima will begin implementing the first stages of California Advancing and Innovating Medi-Cal, or CalAIM. As part of CalOptima's ongoing goal of ensuring providers are prepared for this upcoming change, here is the latest information:

## What is CalAIM?

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.

The proposal was initially released in late 2019, but was put on hold due to the COVID-19 pandemic. A total of $1.6 billion in funding for CalAIM was included in Governor Newsom's fiscal year 2021–22 enacted state budget. CalAIM spans a five-year period from 2022 to 2027, encompasses numerous initiatives and generally expands Medi-Cal managed care plans' responsibilities.

## What is the goal of CalAIM?

The Department of Health Care Services (DHCS) is proposing a whole system, person-centered approach that will result in a better quality of life for members, as well as long-term cost savings and avoidance. The major components of CalAIM build upon the success of previous federal waiver programs, including Whole Person Care (WPC), Health Homes Program (HHP) and the Coordinated Care Initiative (CCI).

CalAIM has three major goals. First, it will help identify and manage member risk and need through whole-person care approaches and address social determinants of health. Second, it is designed to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility. Third, it will improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

## How will it be implemented?

In June, the CalOptima Board of Directors approved the agency's implementation plans for specific elements of CalAIM. CalOptima has been actively engaged in preparing to implement CalAIM, with a particular focus on those programs going live in 2022. Where implementation of CalAIM requires transitions in current programs, including the WPC pilot and HHP, CalOptima's priority will be to create a seamless transition that supports members' ongoing access to needed services.

The first parts of CalAIM to be implemented starting January 1, 2022, are Enhanced Care Management (ECM) and Community Supports, previously known as In Lieu of Services (ILOS).

## What is ECM?

ECM provides comprehensive care management to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries. It will be phased in to serve various populations of focus, starting in January 2022 with individuals and families experiencing homelessness, adult high utilizers, and adults with Serious Mental Illness and Substance Use Disorder. In January 2023, ECM expands to include individuals transitioning from incarceration, eligible for long-term care or at risk of institutionalization, or transitioning from nursing homes to the community. Children and youth with special conditions will also be eligible for ECM starting July 1, 2023.

## What are Community Supports?

Community Supports are offered as a substitute to, or to avoid, other covered services, such as emergency room visits and hospitalizations. CalOptima will implement Community Supports in phases. In Phase 1, CalOptima is committed to offering:

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Recuperative care (medical respite)

For Phase 2, CalOptima surveyed the provider community about the remaining Community Supports to explore future offerings. Under review are 10 additional Community Supports options to be implemented in the future.

To learn more about CalAIM and get referral forms, visit www.caloptima.org/CalAIM.

# Fight COVID-19: Become a Vaccine Provider!

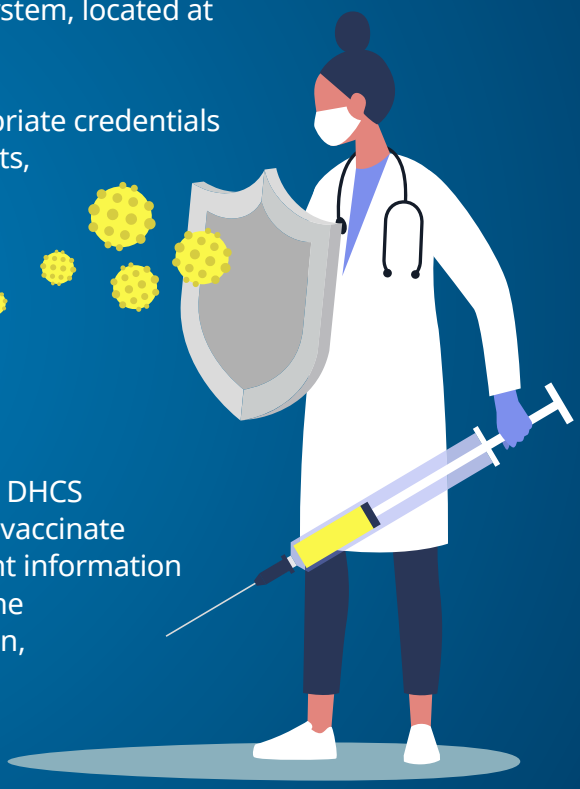
CalOptima is thankful for all providers have done to assist in California's fight against COVID-19. As part of the continual effort to protect members against the pandemic, we also invite providers to consider enrolling with the California Vaccine Management System (myCAvax) to receive and administer COVID-19 vaccines.

Providers interested in participating will need to enroll and complete the training provided by the federal COVID-19 vaccination program. The training is offered through the California Department of Public Health's provider registration and enrollment system, located at https://mycavax.cdph.ca.gov/s/.

To be eligible to administer vaccines, a provider must have the appropriate credentials and licensing for their jurisdiction, meet federal and state requirements, and have the ability to properly maintain and administer the vaccine.

Those interested in becoming a COVID-19 vaccine provider can find more information, including an enrollment kit, FAQs, training, news updates and weekly webinars, on the California COVID-19 Vaccination Program website at https://eziz.org/covid/.

The latest guidelines from the Centers for Disease Control and Prevention recommend everyone age 5 and older receive the vaccine. DHCS also emphasizes that providers use clinical judgment to prioritize and vaccinate individuals deemed to be at high risk from COVID-19. The most current information and guidelines from DHCS about COVID-19 vaccination are found in the agency's revised All Plan Letter 20-22: COVID-19 Vaccine Administration, located at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-022.pdf.



# Are You Ready for Medi-Cal Rx?

As of January 1, 2022, Medi-Cal pharmacy benefits and services will be administered by DHCS in the fee-for-service (FFS) delivery system called Medi-Cal Rx. This transition will create a uniform process for pharmacy providers and prescribers and applies to everyone in Medi-Cal FFS and managed care. All benefits that are billed on a pharmacy claim will be transitioned to Medi-Cal Rx and all Prior Authorizations (PAs) will be reviewed by Medi-Cal Rx starting January 1.

As part of this transition, prescribing providers should request access to the Medi-Cal Rx Secured Provider Portal, which grants access to various applications, education materials, training courses and other resources. At the beginning of November, DHCS also posted a new Prescriber Training Checklist, which is a step-by-step guide for accessing the Medi-Cal Rx Secured Provider Portal, training and other resources.

To access the checklist, visit https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/bulletins/2021.11_A_Alert_Prescriber_Training_Checklist.pdf or search under DHCS' Medi-Cal Rx Bulletins & News page at https://medi-calrx.dhcs.ca.gov/provider/pharmacy-news/.

Please note Internet Explorer is no longer a supported web browser. Providers are asked to used Google Chrome, Microsoft Edge or another supported web browser when trying to access these resources.

Medi-Cal Rx has created a uniform and searchable Contract Drugs List (CDL) for all beneficiaries. It opens up the network to include all pharmacies and has a robust Transition Policy that includes “grandfathering” for previously approved PAs and a 180-day period where DHCS will not require PA for existing prescriptions in order to provide a seamless beneficiary experience.

Be sure to subscribe to the Medi-Cal Rx Subscription Service (MCRxSS) to stay up to date with the latest Medi-Cal Rx news. Use this link to sign up: https://mcrxsspages.dhcs.ca.gov/Medi-CalRxDHCScagov-Subscription-Sign-Up. For questions, please contact the Medi-Cal Rx Customer Service Center at **800-977-2273**, available 24 hours a day, 365 days a year, or email MediCalRxEducationOutreach@magellanhealth.com.

# Remember to Update 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 (SB 137).

This law underscores the importance of ensuring that a provider's information is up to date and any changes are communicated to the provider's contracted health network in a timely manner.

**Specifically, the law requires:**

- A listing of all contracted health networks and services of the provider or provider group
- Providers to notify their contracted health network within five business days if they are no longer accepting new patients or if they were not accepting new patents 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 their 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 SB 137. Providers have 30 business days to confirm with their contracted health network that their information is either current and accurate or requires updates. If no response is received, 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 whether 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**.

# 2020 Pay for Value Payments to Mail Soon

CalOptima's Pay for Value (P4V) team is currently working on completing the scoring and payment calculations for measurement year 2020 (MY2020), with the goal of mailing incentive checks before the close of this year to all eligible providers.

The P4V program encourages providers and health networks to offer quality preventive health care services, deliver excellent outcomes and achieve high levels of member satisfaction. Cash incentives are awarded for achieving certain quality metrics and Healthcare Effectiveness Data and Information Set (HEDIS) measurements.

Providers can continue to monitor their performance on the P4V clinical measures by reviewing the monthly CalOptima Community Network Provider Report Cards distributed via the Provider Portal.

To be eligible to qualify for MY2021 screening or intervention measures, providers should utilize the Member Detail files posted each month to reach out to those members needing services before December 31, 2021.

If providers have any questions about their performance to date, they can contact the P4V team by sending an email to p4vprogram@caloptima.org.

# Important Information for Providers: CalOptima 2021 Member Health Rewards Program

CalOptima offers no-cost rewards to eligible CalOptima members for taking an active role in their health. CalOptima would like to encourage providers to inform members of the benefits of completing tests and screenings at the right time. Please share the following information about no-cost rewards available to eligible CalOptima members.

## Breast Cancer Screening

No-Cost Reward

$25 gift card

**Eligibility Criteria**

CalOptima members ages 50–74 who complete a breast cancer screening mammogram

## Cervical Cancer Screening

No-Cost Reward

$25 gift card

**Eligibility Criteria**

CalOptima Medi-Cal members ages 21–64 who complete a cervical cancer screening

## Colorectal Cancer Screening

No-Cost Reward

$50 gift card

**Eligibility Criteria**

CalOptima OneCare and OneCare Connect members ages 50–75 who complete a sigmoidoscopy or colonoscopy

## Postpartum Checkup

No-Cost Reward

$50 gift card

**Eligibility Criteria**

CalOptima Medi-Cal members who have a postpartum checkup between 1–12 weeks after delivery

For the most up-to-date information on the 2021 CalOptima Member Health Rewards Program, visit https://www.caloptima.org/en/HealthAndWellness/MemberHealthRewards.aspx.

For any questions regarding the Health Rewards Program, contact CalOptima's Health Management department at QI_Initiatives@caloptima.org.

### Diabetes A1C Test

No-Cost Reward
$25 gift card

**Eligibility Criteria**

CalOptima Medi-Cal members ages 18–64 with a diagnosis of diabetes who complete an A1C test

### Diabetes Eye Exam

No-Cost Reward
$25 gift card

**Eligibility Criteria**

CalOptima Medi-Cal members ages 18–64 with a diagnosis of diabetes who complete a diabetes eye exam

### Shape Your Life (SYL)

No-Cost Reward
$50 gift card

**Eligibility Criteria**

CalOptima Medi-Cal members ages 5–18 with a BMI at 85% or higher who participate in a minimum of six SYL classes and complete a follow-up doctor appointment

### COVID-19 Vaccination

No-Cost Reward
Two $25 gift cards for a two-dose vaccine
OR
One $25 gift card for a single-dose vaccine

**Eligibility Criteria**

CalOptima Medi-Cal, OneCare, OneCare Connect and Kaiser members ages 5 and up. All members must be eligible on date of service.

# Annual Diabetic Eye Exam Is an Important Part of Members' Health Care

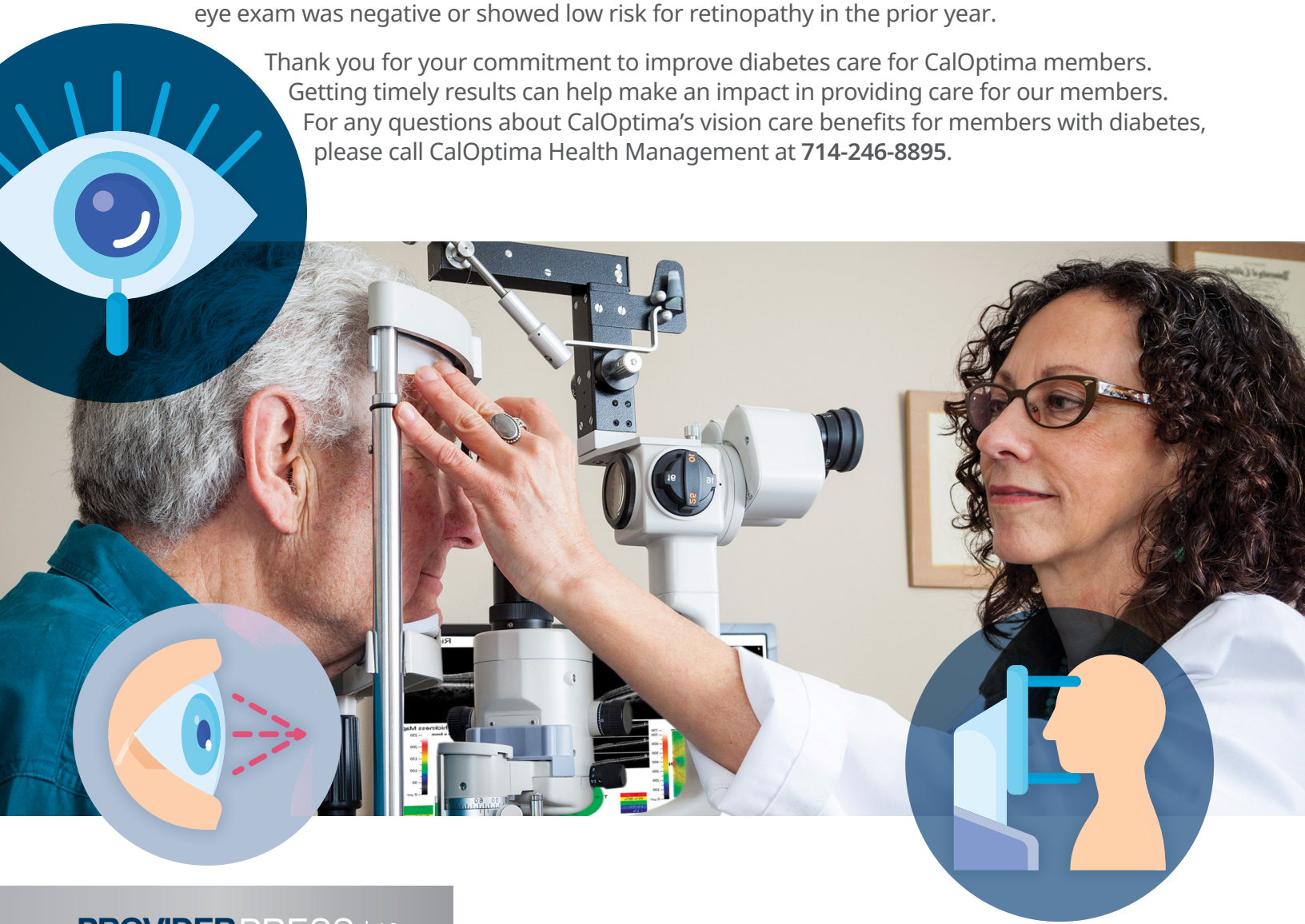
As part of their normal care, members with diabetes should receive a diabetic eye exam, performed through an ophthalmologist referral or contracted Vision Service Plan (VSP) optometrist. CalOptima benefits allow eligible members to have an eye exam annually, though some patients might have delayed this due to COVID-19. Please recommend that all CalOptima members get their eye exam.

For vision care providers, we ask that eye exam results — especially those showing problems such as diabetic retinopathy — be sent to the patient's PCP to ensure continuity of care and timely follow-up services. Providers can get exam results straight from VSP with the member's consent, so please remind patients to provide that information to their vision care specialist.

Providers should add the eye exam report from the vision care professional into the member's chart or record the history of a dilated eye exam with the date of service, test and result into the chart.

Recording a diabetic eye exam by an optometrist or ophthalmologist does not sufficiently meet the measure to be counted for HEDIS. The medical record needs to show that a dilated or retinal exam was performed. If the words "dilated" or "retinal" are missing in the medical records, a note of "dilated drops used" and findings for macula and vessels will meet the measure for a dilated exam. A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results would also count. Use Code 3072F if a member's eye exam was negative or showed low risk for retinopathy in the prior year.

Thank you for your commitment to improve diabetes care for CalOptima members. Getting timely results can help make an impact in providing care for our members. For any questions about CalOptima's vision care benefits for members with diabetes, please call CalOptima Health Management at **714-246-8895**.



# A1C Test Plays Key Role in Diabetes Self-Management

It is vital for patients with diabetes to receive their A1C tests. Some patients may have delayed routine check-ups and lab tests due to COVID-19, so CalOptima is asking providers to urge members with diabetes to have their check-ups and A1C tests done.

To improve our members' health, please highlight the importance of self-management among patients with diabetes. Self-management can create positive effects on patient behaviors and health status. Continue to encourage members to come in for routine visits to monitor their diabetes, especially members who have uncontrolled A1C levels, to prevent adverse complications.

**Here are action items a provider should take to help improve their HEDIS A1C measure:**

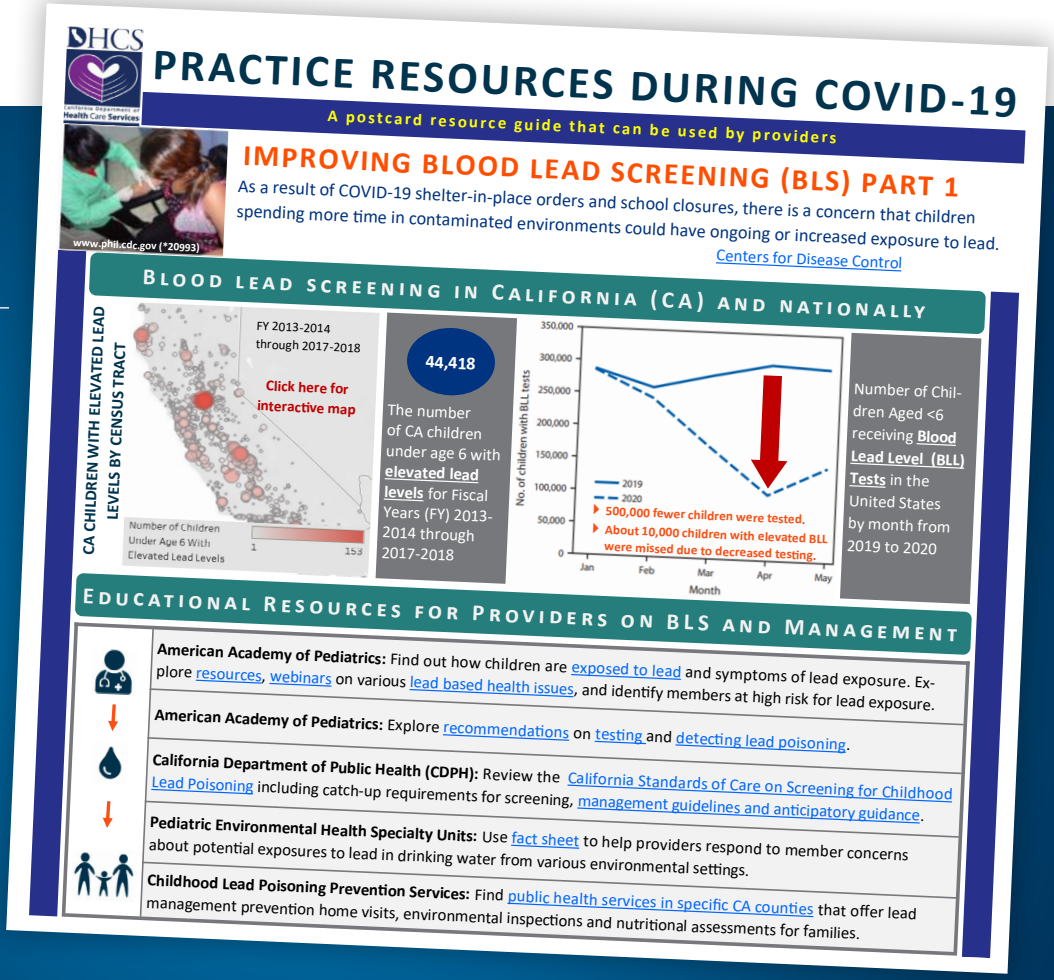
- Review diabetes services needed at each office visit
- Order labs prior to patient appointments
- Ensure A1C result and date are documented in the chart
- Adjust therapy to improve A1C and blood pressure levels; follow-up with patients to track changes
- Prescribe statin therapy to all members with diabetes ages 40–75

Please note, CalOptima has an A1C Test health reward program for Medi-Cal members ages 18–64 with a diagnosis of diabetes who complete an A1C test. For more info, visit: https://www.caloptima.org/en/HealthAndWellness/MemberHealthRewards.aspx.

For any questions about CalOptima's benefits for members with diabetes, please call CalOptima Health Management at **714-246-8895**.

## DHCS Shares Blood Lead Screening Postcards

Due to stay-at-home orders and school closures stemming from the COVID-19 pandemic, there is concern that children could be spending more time in lead-contaminated environments. DHCS has shared these Quality Improvement (QI) "postcards" with information and resources for providers about blood lead screenings. To view the postcard and access the information links, please visit: https://www.chgsd.com/docs/default-source/providers/covid-postcards/dhcs-blood-lead-screening-qi-postcard.pdf?sfvrsn=488df926_0.



# Accessing Interpreter Services

Federal and state regulations require CalOptima and its health networks to provide interpreter services to members with limited English proficiency. Limited English proficient (LEP) members include those who have a limited ability to read, speak, write or understand English.

Providers may request interpreter services for their CalOptima patients with limited English proficiency. Providers may request either telephonic or face-to-face interpreter services, depending upon the situation.

## How to Request Interpreter Services

1. Verify the member's eligibility and identify if the member is enrolled in a health network, CalOptima Community Network or CalOptima Direct.
2. Determine whether telephonic or face-to-face interpreter service is needed.
    - Telephonic interpreter service is recommended for urgent situations or short and simple conversations. This service is available 24 hours a day, seven days a week.
    - Face-to-face interpreter service, including sign language, is recommended when complicated or extensive explanation of treatment or symptoms is required. This service is available for scheduled medical appointments in an ambulatory setting and requires at least five working days' advance notice.

3. Please have the following information ready at the time of the request:
    - Member's name
    - Member's card identification number
    - Member's gender
    - Member's age
    - Date of appointment
    - Time of appointment
    - Language needed
    - Approximate duration
    - Type of visit
    - Name of doctor/facility
    - Address of appointment/ location
    - Phone number of appointment/ location
4. If the member is in CalOptima Direct or CalOptima Community Network, please call CalOptima's Customer Service department at **714-246-8500**. Prior authorization is not required.
5. If the member is in a health network, please use the following list to contact the member's health network after verifying eligibility. The member's health network will work with you and the member to coordinate all interpreter services.

# Health Network Interpreter Services Contact List

| Health Network | Telephonic Interpreter Service Contact | Face-to-Face Interpreter Service Contact |
|---|---|---|
| AltaMed Health Services | 877-462-2582 | 877-462-2582 |
| AMVI Care Health Network | 866-796-4245 | 866-796-4245 |
| CHOC Health Alliance | 800-424-2462 | 800-424-2462 |
| Family Choice Health Network | Language line: 800-611-0111 | 800-611-0111 |
| Kaiser Permanente | 800-464-4000 or 800-777-1370 (TDD/TTY) | 800-464-4000 or 800-777-1370 (TDD/TTY) |
| Noble Mid-Orange County | 888-880-8811 | 888-880-8811 |
| Optum Care Network–Arta | 800-780-8879 | 800-780-8879 |
| Optum Care Network–Monarch | 888-656-7523 | 888-656-7523 |
| Optum Care Network–Talbert | 800-297-6249 | 800-297-6249 |
| Prospect Medical Group | 800-708-3230 | 800-708-3230 |
| Regal Medical Group | 844-292-5173 | 844-292-5173 |
| United Care Medical Network | 877-225-6784 | 877-225-6784 |

# CalOptima Fields In-Office Wait Time Survey

As part of our ongoing quality improvement program, CalOptima continuously monitors timely access to evaluate our members' ability to obtain health care services promptly, including in-office wait times, as required by DHCS. As indicated in CalOptima's Access and Availability Policies, GG.1600 and MA.7007, in-office wait times shall not exceed 45 minutes before a member is seen by a provider.

From January–May 2021, CalOptima conducted a survey of in-office wait time among CalOptima members who visited a primary care provider (PCP) or a specialist during this time. A total of 745 members were called and 179 members, or 24%, provided CalOptima with their in-office wait times. CalOptima is happy to share that 168 members, or 94%, reported being seen by a provider within 45 minutes.

Thank you for continuing to ensure our members have access to timely health care. To continue to assist you with this effort, CalOptima is providing you with a list of timely access standards. If you have any questions or would like to speak with a Provider Relations representative, please call 714-246-8600 or email ProviderServicesinbox@caloptima.org.

## Telephone Access Standards:

| Description | Standard |
|---|---|
| Telephone triage | Telephone triage shall be available 24 hours a day, seven days a week. Telephone triage or screening waiting time shall not exceed 30 minutes. |
| Telephone wait time during business hours | A non-recorded voice within 30 seconds |
| Urgent message during business hours | Practitioner returns the call within 30 minutes after the time of message. |
| Non-urgent and non-emergency messages during business hours | Practitioner returns the call within 24 hours after the time of message. |
| Telephone access after/ during business hours for emergencies | The phone message and/or live person must instruct members to dial 911 or go to the nearest emergency room. |
| After-hours access | A PCP or designee shall be available 24 hours a day, seven days a week, to respond to after-hours member calls or to a hospital emergency room practitioner. |

## Access to Emergency/Urgent Care Services:

| Type of Care | Standard |
|---|---|
| Emergency services | Immediately, 24 hours a day, 7 days a week |
| Urgent care services | Within 24 hours of request |

## Access to Primary Care:

| Type of Care | Standard |
|---|---|
| Urgent appointments that **DO NOT** require prior authorization | Within 48 hours of request |

## Access to Primary Care: (Continued)

| Type of Care | Standard |
|---|---|
| Non-urgent primary care | Within 10 business days of request |
| Routine physical exams and wellness visits | Within 30 calendar days of request |
| Medi-Cal only Initial Health Assessment (IHA) or Individual Health Education Behavioral Assessment (IHEBA) | Medi-Cal Only: Within 120 calendar days of Medi-Cal enrollment |

## Access to Specialty and Ancillary Care:

| Type of Care | Standard |
|---|---|
| Urgent appointments that **DO NOT** require prior authorization | Within 48 hours of request |
| Urgent appointments that **DO** require prior authorization | Within 96 hours of request |
| Non-urgent specialty care | Within 15 business days of request |
| First prenatal visit | OneCare Connect/OneCare: Within 2 weeks of request |
| Non-urgent ancillary services | Within 15 business days of request |

## Access to Behavioral Health Care:

| Type of Care | Standard |
|---|---|
| Non-urgent care with a mental health outpatient services provider | Within 10 business days of request |
| Follow-up routine care with a mental health outpatient services provider | Within 20 calendar days of initial visit for a specific condition |
| Follow-up routine care with a physician behavioral health care provider | Within 30 calendar days of initial visit for a specific condition |

## Other Access Standards:

| Description | Standard |
|---|---|
| In-office wait time for appointments | Less than 45 minutes before being seen by a provider |
| Rescheduling appointments | Appointments will be rescheduled in a manner appropriate to the member's health care needs and that ensures continuity of care is consistent with good professional practice. |

## CalOptima Meeting Information

Unless otherwise specified, meetings take place in the assembly rooms on the first floor at CalOptima, 505 City Parkway West in Orange. However, due to COVID-19, it is recommended that those wishing to participate attend virtually. To select which virtual meeting you would like to attend, visit the CalOptima website at: *https://www.caloptima.org/en/About/AboutCalOptima/Committees.aspx*. For more information, please call **714-246-8600**.

**CalOptima Board of Directors***
**2 p.m.**
- February 3, 2022
- March 3, 2022
- April 7, 2022

**CalOptima Board of Directors' Investment Advisory Committee***
**3 p.m.**
- January 24, 2022

**CalOptima Board of Directors' Finance and Audit Committee***
**2 p.m.**
- February 17, 2022

**CalOptima Board of Directors' Quality Assurance Committee***
**5:30 p.m.**
- March 9, 2022

**Member Advisory Committee (MAC)***
**2:30 p.m.**
- February 10, 2022
- March 10, 2022

**OneCare Connect Member Advisory Committee (OCC MAC)* 3 p.m.**
- February 24, 2022

**Provider Advisory Committee (PAC)***
**8 a.m.**
- February 10, 2022
- March 10, 2022

**Whole-Child Model Family Advisory Committee (WCMFAC)* 9:30 a.m.**
- February 22, 2022

**Public meeting*

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# How to Refer Members for Case Management Services

Are you treating a CalOptima Medi-Cal or OneCare member and need to know how you can refer them for case management services? Providers may refer members who are with a delegated CalOptima Medi-Cal health network or OneCare physician medical group (PMG) directly for case management by:

- Contacting the member's assigned health network or PMG directly
- Contacting Case Management at **714-246-8686**
- Faxing a template requesting case management services to the Case Management triage inbox at **714-571-2455**
- Faxing a template requesting case management services to OneCare Clinical at **714-571-2240**
- Emailing information to the Case Management triage inbox at **cmtriage@caloptima.org**
- Emailing information requesting case management services to the OneCare Clinical team at **OneCareClinical@caloptima.org**

## 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**.

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