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

WEDNESDAY, MARCH 9, 2022
3:00 P.M.

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

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

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo KENNADAY LEAVITT	Sharon Dwiers

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

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

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

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

1) **Participate via Zoom Webinar at:**
https://zoom.us/webinar/register/WN_BjK8qccwTj2623iW1NjFQA and Join the Meeting.
Webinar ID: **978 7409 5216**
Passcode: **908717** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

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

CONSENT CALENDAR
1. Approve Minutes of the December 8, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

2. Approve Modifications to CalOptima Quality Improvement Policies: GG.1603, GG.1607, GG.1650, GG.1651, and GG.1655

REPORT ITEMS
3. Receive and File 2021 CalOptima Quality Improvement Program Evaluation and Recommend Board of Directors Approval of the 2022 Quality Improvement Program and 2022 Quality Improvement Work Plan

4. Receive and File 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2022 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

INFORMATION ITEMS
5. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee on March 9, 2022 at 3:00 p.m. (PST)

https://zoom.us/webinar/register/WN_BjK8qccwTj2623iW1NjFQA

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

Or One tap mobile:
+16699009128,,97874095216#,,,,*908717# US (San Jose)
+12532158782,,97874095216#,,,,*908717# US (Tacoma)

Or join by phone:
Dial (for higher quality, dial a number based on your current location):
US: +1 669 900 9128 or +1 253 215 8782 or +1 346 248 7799 or +1 646 558 8656 or +1 301 715 8592 or +1 312 626 6799

Webinar ID: 978 7409 5216

Passcode: 908717

International numbers available: https://zoom.us/u/abDcQswZQx

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

December 8, 2021

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on December 8, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing provisions of the Brown Act.

Acting Chair Trieu Tran, called the meeting to order at 3:02 p.m. Clerk of the Board Sharon Dwiers led the Pledge of Allegiance.

MANAGEMENT REPORTS
None.

PUBLIC COMMENTS
There were no requests for public comment.

CALL TO ORDER

Members Present: Nancy Shivers, R.N.; Trieu Tran, M.D. (all members participated via teleconference)

Members Absent: None.

Others Present: Michael Hunn, Interim Chief Executive Officer (absent); Gary Crockett, Chief Counsel, Yunkyung Kim, Chief Operating Officer; Emily Fonda, M.D., Chief Medical Officer; Marie Jeannis, Executive Director of Quality & Population Health Management, Sharon Dwiers, Clerk of the Board

CONSENT CALENDAR

1. Approve the Minutes of the September 8, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Shivers, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 2-0-0)***

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REPORTS

2. Consider Recommending Board of Directors Authorize Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022

Marie Jeannis, Executive Director, Quality & Population Health Management, introduced the item and provided an overview of the vaccine incentive program.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors 1.) Extend CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program through Calendar Year 2022 (CY 2022) and Authorize the Provision of Vaccine Incentives for Members who Receive Booster or Additional Doses of the COVID-19 Vaccine; and. 2.) Authorize Use of the Previously Approved Allocation of Unspent IGT 10 Funds, Not to Exceed the Original Funding Level of $35 Million, to Include Provision of a $25 Non-monetary Gift Card (one gift card per shot) to Individual Medi-Cal Members who Receive a Booster or Additional dose of the COVID-19 Vaccine. (Motion carried 2-0-0)***

3. Consider Recommending Board of Directors Approval of Proposed Changes to CalOptima Quality Improvement Policy GG.1608: Full Scope Site Reviews

Ms. Jeannis introduced the item and provided an overview of the proposed policy changes.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors Approve Proposed Changes to CalOptima Policy GG.1608: Full Scope Site Reviews (Motion carried 2-0-0)***

4. Consider Recommending Board of Directors Approval of the Calendar Years 2022 and 2023 Health Network Medi-Cal Pay for Value Performance Program

Kelly Rex-Kimmet, Director, Quality Analytics, introduced the item.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors Approve the Calendar Years (CYs) 2022 and 2023 Health Network Medi-Cal Pay for Value Performance Program for the Measurement Period Effective January 1, 2022, through December 31, 2023. (Motion carried 2-0-0)***

5. Consider Recommending Board of Directors Approval of the Calendar Year 2022 Health Network OneCare Connect Pay for Value Program Payment Methodology

Ms. Rex-Kimmet introduced the item.

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Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors Approve the Calendar Year (CY) 2022 Health Network OneCare Connect (OCC) Pay for Value (P4V) Performance Program for the Measurement Period Effective January 1, 2022, through December 31, 2022. (Motion carried 2-0-0)***

6. Consider Recommending that the Board of Directors Extend the Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy for Calendar Year 2022

Ms. Jeannis introduced the item.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: 1.) Extend CalOptima's Homeless Health Initiative Vaccination Incentive Strategy through Calendar Year 2022, and Authorize the Provision of Vaccine Incentives for Members who Receive Booster or Additional Doses of the Coronavirus Disease (COVID-19) Vaccine; and 2.) Authorize Use of the Previously Approved Allocation of Homeless Health Initiative Funds, Not to Exceed the Original Funding Level of $400,000, to Include Provision of a $25 Nonmonetary Gift Card (one gift card per shot) to Members Experiencing Homelessness who Receive a Booster or Additional Dose of the COVID-19 Vaccine.(Motion carried 2-0-0)***

INFORMATION ITEMS

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

Monica Macias, Director, PACE Program, provided an update on the PACE Member Advisory Committee activities. Ms. Macias noted that the PACE facility continues use the revised protocols in place since the pandemic and is closely monitoring the new Omicron variant.

The following items were accepted as presented.

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

COMMITTEE MEMBER COMMENTS

The Committee members thanked staff for the work that went into preparing for the meeting.

ADJOURNMENT

Hearing no further business, Acting Chair Tran adjourned the meeting at 3:29pm. The next Quality Assurance Committee meeting is scheduled for March 9, 2021.

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Sharon Dwiers
Clerk of the Board

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 9, 2022
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Consent Calendar

2. Approve Modifications to CalOptima Quality Improvement Policies: GG.1603, GG.1607, GG.1650, GG.1651, and GG.1655

Contacts

Richard Pitts, Chief Medical Officer, (714) 246-8491
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Actions

Approve recommended modifications to the following existing Policies and Procedures, in accordance with CalOptima's regular review process and regulatory requirements:

1. Policy GG.1603: Medical Records Maintenance
2. Policy GG.1607: Monitoring Adverse Actions
3. Policy GG.1650: Credentialing and Recredentialing of Practitioners
4. Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
5. Policy GG.1655: Reporting Provider Preventable Conditions (PPC)

Background/Discussion

CalOptima staff regularly reviews agency policies and procedures to ensure that they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations, and laws, as well as CalOptima Operations.

Below is a description of the impacted policies, followed by a list of recommended substantive changes to each policy, which are reflected in the attached redlines. The list does not include non-substantive changes that may also be reflected in the redline (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Additionally, glossaries for all policies have been updated to add or clarify existing definitions for interpreter, provider, organizational provider, non-physician medical practitioner, appeal, grievance, member, continuity of care, and durable medical equipment, as applicable.

1. **Policy GG.1603: Medical Records Maintenance** defines the minimum standards for maintaining a Member's Medical Records.

Policy Section	Change
Page 3. Section III.C.4.ix	Clarified that refusal of free interpreter services and request to use family member, friends, or minor child must be documented in the member's medical records in alignment with All Plan Letter (APL) 21-004: Standards for Determining Threshold Language, Nondiscrimination Requirements, and Language Assistance Services

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2. **Policy GG.1607: Monitoring Adverse Actions** establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and/or other entities against CalOptima Practitioners or Organizational Providers.

Policy Section	Change
Page 2. Section II. B.8-15 Page 3. Section III. B.9-10	Updated policy to reflect current operational practices and detail all required Federal and State database checks in alignment with APL 19-004: Provider Credentialing Recredentialing and Screening Enrollment and Senate Bill (SB)857 and Welfare and Institution Code (W&I Code), Section 14044
Pages 16-52 Attachment A	Updated website links and added additional verification sites to Attachment A. Ongoing Monitoring Website Information Matrix

3. **Policy GG.1650: Credentialing and Recredentialing of Practitioners** defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners for participation in CalOptima programs.

Policy Section	Change
Page 6. Section III.A.3. f.	Clarified Malpractice Insurance Limits for Behavioral Health Service providers
Page 7. Section III.A.3. r.	Clarified that active enrollment includes verification that Provider did not Opt-out of Medicare Program
Page 9. Section III.D.3.a. ii.	Clarified that clean file list are approved by a Medical Director
Pages 55-68. Attachment B	Added additional resources to Attachment B. CalOptima Primary Source Verification Table

4. **Policy GG.1651: Assessment and Re-Assessment of Organizational Providers** describes the process by which CalOptima evaluates and determines an OPs eligibility to participate in CalOptima Program.

Policy Section	Change
Page 3. Section III.A.2.b. xii-xiii	Updated to include additional accreditation bodies used to verify hospitals and dialysis centers
Page 3. Section III.A.2.f.	Clarified that active enrollment includes verification that Provider did not Opt-out of Medicare Program
Page 5. Section III.D.2.ii.	Clarified that clean file list are approved by a Medical Director

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5. **Policy GG.1655: Reporting Provider Preventable Conditions (PPC)** describes the method by which CalOptima reports PPC to the Department of Health Care Services (DHCS).

Policy Section	Change
Pages 1-2. Section II	Policy updated to include references to relevant plan letters and CalOptima policies; FF.2001: Claims Processing for Covered Services and HH.2022Δ: Record Retention and Access, for additional clarity

Fiscal Impact

The recommended action to modify policies GG.1603, GG.1607, GG.1650, GG.1651 and GG.1655 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable laws, regulations, rules, and accreditation standards. CalOptima staff recommends that the Board of Directors approve and adopt the presented CalOptima policies and procedures. The updated policies and procedures will supersede prior versions

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Policy GG.1603: Medical Records Maintenance (Redlined and Clean)
2. GG.1603_APL 21-004_Threshold, Nondiscrimination, and Language Assistance
3. Policy GG.1607: Monitoring Adverse Actions (Redlined and Clean)
4. GG.1607_APL 19-004_Provider Credentialing Recredentialing and Screening enrollment
5. GG.1607_SB 857 and Welfare and Institutions Code (W&I Code), Section 14044
6. Policy GG.1650: Credentialing and Recredentialing of Practitioners (Redlined and Clean)
7. Policy GG.1651_Assessment and Re-Assessment of Organizational Providers_Final QAC Packet
8. Policy GG.1655_Reporting Provider Preventable Conditions (PPC)_QAC Final Packet

/s/ Michael Hunn *03/04/2022*
Authorized Signature **Date**

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Policy:	GG.1603
Title:	**Medical Records Maintenance**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's Medical Records.

II. POLICY

A. A Practitioner ~~and~~or Provider~~,~~ shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner or Provider shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. A Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

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b. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service;

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.b. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory reports;

b. X-ray reports;

c. Electroencephalograms (EEGs);

d. Echocardiograms (EKGs);

e. Consultation reports;

f. Hospital reports (admission/outpatient procedures); and

g. Emergency department reports.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. The record shall be in a legible hand-written or a printed format.

3. The record shall reflect the findings of each visit or encounter, including, but not limited to:

a. Recording date of service;

b. Chief complaints;

c. Unresolved and/or continuing problems addressed in subsequent visit(s);

d. Tests or therapies ordered;

e. Treatment plan and diagnosis or medical impression;

f. Any physical, psychosocial, or educational needs identified during the encounter; and

g. Abnormal results.

4. The following data sets shall be included in each Medical Record:

a. Demographic information, including, but not limited to:

i. Name and address;

ii. Age and birth date;

iii. Sex;

iv. Telephone number;

v. Emergency contact person and nearest relative (phone numbers for each);

vi. Plan Identification;

vii. Medi-Cal Number, as applicable;

viii. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

ix. Requests for language and/or interpretation services by a non-or limited-English proficient ~~member~~Member are documented, as applicable. ~~Member~~Member's refusal of ~~interpreter~~free Interpreter services ~~may~~and their request to use family members, friends, or a in an emergency only, a minor child as an Interpreter shall be documented ~~at least once and be accepted throughout~~in the Member's ~~care, unless otherwise specified~~Medical Record; and

x. Person or entity providing medical interpretation is identified, as applicable for each encounter.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

1) Height;

2) Weight (body mass index) (BMI);

3) Temperature;

4) Pulse and respirations;

5) Blood pressure if the Member is at least three (3) years of age; and

6) Signature/title of person performing these functions.

iv. Allergies and adverse reactions prominently noted (recorded on front of record or on standardized location within the record);

v. Problem(s) list, maintained with current updates;

vi. List of medications, maintained with current updates, including:

1) Name;

2) Strength;

3) Dosage; and

4) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

1) Significant health problems;

2) Reactions to drugs; and

3) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

1) History and physical;

2) Discharge summary;

3) Operative reports; and

4) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

1) Assessment;

~~1)~~2) Treatment;

~~2)~~3) Discharge instructions; and

~~3)~~4) Recommended follow-up.

xiii. Prescriptions.

c. Preventive Care

i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

ii. Preventive care and health maintenance services rendered;

iii. Initial Health Assessment (IHA);

iv. Initial Individualized Health Education Behavioral Assessment (IHEBA);

v. Timely provision of immunizations in accordance with the most recent schedule and recommendations published by ACIP, regardless of Member's age, sex, or medical condition, including pregnancy; and

~~iv.~~vi. Complete record of immunizations. Immunizations shall be recorded with name, manufacturer, lot number, and expiration date, and Vaccine Information Statement (VIS) documentation.

~~v.~~vii. Evidence of member-specific immunization information reported to California Immunization Registry (CAIR).

d. Additional Medical Record components and consents:

i. Adults 18 years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive.

1) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

2) Advance Health Care Directive Information is reviewed with the member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information.

iv. Authorization Request Forms (ARFs);

v. Referrals;

vi. Significant telephone advice, documented with date, time, and signature;

vii. For services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

viii. Consultation reports;

e. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

D. Recall System for No-Show Members

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. All attempts to reach the Member.

b. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

E. Confidentiality of Records

1. All Member records and Member-related information shall be handled with strict confidentiality.

2. The Medical Records Department Manager or Office Manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping Member information confidential, and in the release of Member information when requested by the Member or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, CalOptima HIPAA privacy policies, and applicable state and federal laws.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract for Health Care Services
E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
F. CalOptima Policy GG.1618: Member Request for Medical Records
~~G. Department of Health Care Services (DHCS) Policy Letter (PL) 99-003: Cultural and Linguistics~~
~~H.~~G. Department of Health Care Services (DHCS) All Plan Letter (APL) 05-010: Advanced Directive Form
~~I.~~H. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-004: Immunization Requirements
~~J.~~I. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009: Telehealth Services Policy
~~K.~~J. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006: Site Reviews: Facility Site Review and Medical Record Review
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
L. Title 22, California Code of Regulations (CCR), §75055
M. Title 28, California Code of Regulations (CCR), §§1300.67.1(c) and 1300.80(b)(4)
N. Title 42, United States Code, §1396a(w)
O. California Welfare & Institutions Code §14124.1
P. California Probate Code §§~~-~~4701 and 4780-4785
Q. California Business and Professions Code §2290.5
R. Title 42, Code of Federal Regulations (CFR) §§422.128 and 489.100
~~S. Standards for Determining Threshold Languages and Requirement For Section 1557 Of The Affordable Care Act (APL) 17-011~~

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/10/2010	Department of Health Care Services (DHCS)
03/19/2021	Department of Health Care Services (DHCS)
12/14/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	11/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/2007	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2010	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2013	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	08/01/2015	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	03/01/2019	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
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.
Individualized Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a PCP in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
Interpreter	A person who renders a message spoken in one language into one or more languages. An Interpreter must be qualified per requirements outlined in Welfare and Institutions Code, section 14029.91(a)(1)(B) and Title 45 Code of Federal Regulations, section 92.101(b)(3).
Medical Record	Medi-Cal: 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. OneCare ~~/~~& OneCare Connect: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima program.
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.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Provider	~~All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.~~Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

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Policy:	GG.1603
Title:	**Medical Records Maintenance**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's Medical Records.

II. POLICY

A. A Practitioner or Provider shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner or Provider shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. A Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

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b. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service;

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.b. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory reports;

b. X-ray reports;

c. Electroencephalograms (EEGs);

d. Echocardiograms (EKGs);

e. Consultation reports;

f. Hospital reports (admission/outpatient procedures); and

g. Emergency department reports.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. The record shall be in a legible hand-written or a printed format.

3. The record shall reflect the findings of each visit or encounter, including, but not limited to:

a. Recording date of service;

b. Chief complaints;

c. Unresolved and/or continuing problems addressed in subsequent visit(s);

d. Tests or therapies ordered;

e. Treatment plan and diagnosis or medical impression;

f. Any physical, psychosocial, or educational needs identified during the encounter; and

g. Abnormal results.

4. The following data sets shall be included in each Medical Record:

a. Demographic information, including, but not limited to:

i. Name and address;

ii. Age and birth date;

iii. Sex;

iv. Telephone number;

v. Emergency contact person and nearest relative (phone numbers for each);

vi. Plan Identification;

vii. Medi-Cal Number, as applicable;

viii. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

ix. Requests for language and/or interpretation services by a non-or limited-English proficient Member are documented, as applicable. Member's refusal of free Interpreter services and their request to use family members, friends, or a in an emergency only, a minor child as an Interpreter shall be documented in the Member's Medical Record; and

x. Person or entity providing medical interpretation is identified, as applicable for each encounter.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

1) Height;

2) Weight (body mass index) (BMI);

3) Temperature;

4) Pulse and respirations;

5) Blood pressure if the Member is at least three (3) years of age; and

6) Signature/title of person performing these functions.

iv. Allergies and adverse reactions prominently noted (recorded on front of record or on standardized location within the record);

v. Problem(s) list, maintained with current updates;

vi. List of medications, maintained with current updates, including:

1) Name;

2) Strength;

3) Dosage; and

4) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

1) Significant health problems;

2) Reactions to drugs; and

3) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

1) History and physical;

2) Discharge summary;

3) Operative reports; and

4) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

1) Assessment;

2) Treatment;

3) Discharge instructions; and

4) Recommended follow-up.

xiii. Prescriptions.

c. Preventive Care

i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

ii. Preventive care and health maintenance services rendered;

iii. Initial Health Assessment (IHA);

iv. Initial Individualized Health Education Behavioral Assessment (IHEBA);

v. Timely provision of immunizations in accordance with the most recent schedule and recommendations published by ACIP, regardless of Member's age, sex, or medical condition, including pregnancy; and

vi. Complete record of immunizations. Immunizations shall be recorded with name, manufacturer, lot number, and expiration date, and Vaccine Information Statement (VIS) documentation.

vii. Evidence of member-specific immunization information reported to California Immunization Registry (CAIR).

d. Additional Medical Record components and consents:

i. Adults 18 years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive.

1) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

2) Advance Health Care Directive Information is reviewed with the member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information.

iv. Authorization Request Forms (ARFs);

v. Referrals;

vi. Significant telephone advice, documented with date, time, and signature;

vii. For services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

viii. Consultation reports;

e. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

D. Recall System for No-Show Members

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. All attempts to reach the Member.

b. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

E. Confidentiality of Records

1. All Member records and Member-related information shall be handled with strict confidentiality.

2. The Medical Records Department Manager or Office Manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping Member information confidential, and in the release of Member information when requested by the Member or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, CalOptima HIPAA privacy policies, and applicable state and federal laws.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract for Health Care Services
E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
F. CalOptima Policy GG.1618: Member Request for Medical Records
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 05-010: Advanced Directive Form
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-004: Immunization Requirements
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009: Telehealth Services Policy
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006: Site Reviews: Facility Site Review and Medical Record Review
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
L. Title 22, California Code of Regulations (CCR), §75055
M. Title 28, California Code of Regulations (CCR), §§1300.67.1(c) and 1300.80(b)(4)
N. Title 42, United States Code, §1396a(w)
O. California Welfare & Institutions Code §14124.1
P. California Probate Code §§4701 and 4780-4785
Q. California Business and Professions Code §2290.5
R. Title 42, Code of Federal Regulations (CFR) §§422.128 and 489.100

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

05/10/2010	Department of Health Care Services (DHCS)
03/19/2021	Department of Health Care Services (DHCS)
12/14/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	11/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/2007	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2010	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2013	GG.1603	Medical Records Maintenance	Medi-Cal OneCare
Revised	08/01/2015	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	11/01/2017	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	03/01/2019	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
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State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: April 8, 2021

ALL PLAN LETTER 21-004
SUPERSEDES ALL PLAN LETTER 17-011 AND
POLICY LETTERS 99-003 AND 99-004

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: STANDARDS FOR DETERMINING THRESHOLD LANGUAGES, NONDISCRIMINATION REQUIREMENTS, AND LANGUAGE ASSISTANCE SERVICES

PURPOSE:
This All Plan Letter (APL) serves to inform all Medi-Cal managed care health plans (MCPs) of the dataset for threshold and concentration languages and clarifies the threshold and concentration standards specified in state and federal law and MCP contracts. This dataset identifies the threshold and concentration languages in which, at a minimum, MCPs must provide written translated member information.

This APL also provides guidance on federal and state requirements regarding nondiscrimination, discrimination grievance procedures, language assistance, and communications with individuals with disabilities as set forth in the federal regulations implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA),[1] Title 42 of the Code of Federal Regulations (CFR) Part 438,[2] Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017),[3] and SB 1423 (Hernandez, Chapter 568, Statutes of 2018).[4]

BACKGROUND:

DHCS Threshold and Concentration Standard Languages
Federal law[5] requires the Department of Health Care Services (DHCS) to establish a methodology for identifying the prevalent non-English languages spoken by eligible beneficiaries throughout the state, and in each MCP's service area, for the purpose of

[1] 45 CFR, Part 92 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=5294f5df71aa8d51bd6be5f16bb9aab2&mc=true&node=pt45.1.92&rgn=div5#_top
[2] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=9a6ca82b62335f91daacca12e91a0c5c&mc=true&node=pt42.4.438&rgn=div5
[3] SB 223 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB223
[4] SB 1423 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB1423
[5] 42 CFR 438.10(d)(1)

requiring MCPs to provide written translations of member information in these languages.[6] State law[7] requires DHCS to identify these languages by calculating whether individuals who speak a non-English language meet certain numeric thresholds, or are geographically concentrated in certain ZIP codes. Pursuant to these laws, DHCS determines the languages in which, at a minimum, MCPs must provide translated written member information. DHCS refers to these languages as the threshold and concentration standard languages.

Nondiscrimination, Language Assistance, and Effective Communication for Individuals with Disabilities

Section 1557 (Title 42 of the United States Code (USC), Section 18116)[8] is the nondiscrimination provision of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on the following long-standing federal civil rights laws and incorporates all of the existing nondiscrimination requirements of those laws: Title VI of the Civil Rights Act of 1964 (Title VI), Title IX of the Education Amendments of 1972 (Title IX), Section 504 of the Rehabilitation Act of 1973 (Section 504), and the Age Discrimination Act of 1975 (Age Act). Section 1557 requires covered programs to ensure effective communication with individuals with disabilities and provide meaningful access to individuals with limited English proficiency (LEP) who are eligible to be served, or likely to be encountered, in health programs and activities.[9] Covered programs include any health program or activity, any part of which receives federal financial assistance from the United States Department of Health and Human Services (HHS); any program or activity administered by HHS under Title I of the ACA; or any program or activity administered by any entity established under such Title. These requirements apply to MCPs' Medi-Cal lines of business.

HHS Office for Civil Rights (OCR) implemented Section 1557 through federal regulations set forth in Part 92 of Title 45 of the CFR in May of 2016. The 2016 version of these regulations included a requirement that covered health programs include a nondiscrimination notice and language taglines in non-English languages advising of the availability of free language assistance services in certain communications and publications. On June 19, 2020, HHS OCR published revised regulations eliminating these specific requirements and replacing them with a four-factor analysis that a covered program must engage in to determine the level of language assistance required under federal law.[10]

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[6] 42 CFR 438.10(d)(2)-(3)
[7] Welfare and Institutions Code (WIC), Section 14029.91 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14029.91.
[8] The USC is searchable at: http://uscode.house.gov/
[9] See, e.g., 45 CFR 92.101 and 92.102 (HHS regulations issued pursuant to Section 1557).
[10] 45 CFR 92.101

Although the specific federal requirements relating to nondiscrimination notices and language taglines in Part 92 of Title 45 of the CFR have been repealed, MCPs must continue to provide nondiscrimination notices and language taglines under the four-factor analysis and state law, consistent with APL 20-015: State Nondiscrimination and Language Assistance Requirements[11] and this APL. In addition, 42 CFR Part 438 contains complementary language assistance requirements specific to MCPs, such as the requirement to provide taglines in the prevalent non-English languages in the state, in a conspicuously visible font size, explaining the availability of written translation or oral interpretation services and how to request auxiliary aids and services for people with disabilities.[12]

MCPs are also subject to federal requirements contained in the Americans with Disabilities Act (ADA), including standards for communicating effectively with people with disabilities to ensure they benefit equally from government programs.[13] Additional communication-related regulations are set forth in Title 42 CFR section 438.10.

In California, SB 223 and SB 1423 codified into state law certain nondiscrimination and language assistance service requirements specific to DHCS[14] and MCPs.[15] SB 223 and SB 1423 also incorporated additional characteristics protected under state nondiscrimination law, including gender, gender identity, marital status, ancestry, religion, and sexual orientation.[16]

POLICY:

DHCS Threshold and Concentration Language Requirements

Member information[17] is essential information regarding access to and usage of MCP services. MCPs are required to provide translated written member information, using a

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[11] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[12] 42 CFR 438.10(d)(2)-(3).
[13] ADA Title II Regulations are available at: https://www.ada.gov/regs2010/titleII_2010/titleII_2010_regulations.htm.
[14] WIC 14029.92, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14029.92.&lawCode=WIC
[15] WIC 14029.91
[16] WIC 14029.92 and 14029.91. For additional state-law-protected characteristics, see Government Code (GOV), section 11135, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=11135.&lawCode=GOV
[17] Member information includes documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to, the Member Handbook/Evidence of Coverage; provider directory; welcome packets; marketing information; form letters, including Notice of Action letters and any notices related to Grievances, actions, and Appeals, including Grievance and Appeal acknowledgement and resolution letters; plan generated preventive health

qualified translator (see requirements for qualified translators in the section on Written Translation below), to the following language groups within their service areas, as determined by DHCS:

- A population group of eligible beneficiaries[18] residing in the MCP's service area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
- A population group of eligible beneficiaries residing in the MCP's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

The updated dataset attached to this APL delineates the required threshold and concentration languages, as determined by DHCS, for the above-mentioned groups within each MCP's service area(s). DHCS updates this dataset at least once every three fiscal years to address potential changes to both numeric threshold and concentration standard languages as well as to reflect changes necessitated by state and federal law. DHCS is providing an updated dataset with this APL iteration and MCPs must comply with the update within 180 days of the publication of this APL.

Nondiscrimination, Language Assistance, and Effective Communication for Individuals with Disabilities

MCPs must comply with all of the nondiscrimination requirements set forth under federal and state law and this APL. This includes the posting of the nondiscrimination notice in member information and all other informational notices, and the provision of the required taglines that inform LEP individuals of the availability of free language assistance services and auxiliary aids and services for people with disabilities.

DHCS has updated its template of the nondiscrimination notice to conform with state law, including SB 223 and SB 1423, and the requirements in this APL, as well as to include contact information for members to file a discrimination grievance directly with

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reminders (e.g., appointments and immunization reminders, initial health examination notices and prenatal follow-up); member surveys; notices advising LEP persons of free language assistance; and newsletters. Examples of Member Information can also be found in APL 18-016: Readability and Suitability of Written Health Education Materials, which is available at the following link: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx#2011.

[18] "Eligible beneficiary" is defined in the MCP contract as any Medi-Cal beneficiary who is residing in the MCP's service area with one of the covered aid codes. Note: threshold language calculations include all Medi-Cal beneficiaries who are "eligible" to enroll, either mandatorily or by choice, in the MCP in the county and are not based on actual MCP enrollment.

the DHCS OCR. DHCS has also updated its taglines template to conform to changes in federal law and to include additional languages to maintain consistency in translation with Medi-Cal fee-for-service (FFS). DHCS does not require MCPs to use the DHCS-provided template language verbatim as long as all notices and associated taglines are compliant with federal and state law and the requirements contained in this APL. All MCP nondiscrimination notices must include information about how to file a discrimination grievance directly with DHCS OCR, in addition to information about how to file a discrimination grievance with the MCP and HHS OCR (i.e., file a grievance with HHS OCR if there is a concern of discrimination based on race, color, national origin, age, disability, or sex).

MCPs must immediately, but in no event later than 180 days following the publication of this APL iteration, update their nondiscrimination notices and taglines to align with the templates language provided with this APL. MCPs must submit these deliverables to DHCS for review and approval prior to use.[19]

MCPs are required to make the nondiscrimination notice available, upon request or as otherwise required by law, in the threshold and concentration languages,[20] or in an ADA-compliant, accessible format.[21]

Nondiscrimination Notice
MCPs must post a nondiscrimination notice (see the attached DHCS template for the nondiscrimination notice) that informs members, potential enrollees,[22] and the public about nondiscrimination, protected characteristics, and accessibility requirements, and conveys the MCP's compliance with the requirements. MCPs are not prohibited from using a more inclusive list of protected characteristics than those included in the DHCS-provided template, as long as all protected characteristics listed in the DHCS-provided template are included.

The nondiscrimination notice must be posted in at least a 12-point font[23] and be included in the Member Handbook/Evidence of Coverage, member information, and all other informational notices targeted to members, potential enrollees, and the public.[24]

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[19] The DHCS templates for the nondiscrimination notice and taglines are provided as attachments to this APL.
[20] WIC 14029.91(a)(2)
[21] 45 CFR 92.202
[22] "Potential enrollee" is defined in the MCP contract as a Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan.
[23] Per 42 CFR 438.10, the font size must be no smaller than 12-point font.
[24] WIC 14029.91(f)

Informational notices include not only documents intended for the public, such as outreach, education, and marketing materials, but also written notices requiring a response from an individual and written notices to an individual such as those pertaining to rights or benefits. Additionally, the nondiscrimination notice must be posted in at least a 12-point font in conspicuous physical locations where the MCP interacts with the public,[25] as well as on the MCP's website in a location that allows any visitor to the website to easily locate the information.[26] The nondiscrimination notice must include all legally-required elements,[27] as well as information on how to file a discrimination grievance directly with DHCS OCR, in addition to information about how to file a discrimination grievance with the MCP and HHS OCR, as provided in the DHCS nondiscrimination notice template.

MCPs are not prohibited from posting the nondiscrimination notice in additional publications and communications.

Discrimination Grievances
MCPs must designate a discrimination grievance coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements. The MCP's discrimination grievance coordinator must investigate grievances alleging any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination laws.[28] MCPs must also adopt grievance procedures that provide for the prompt and equitable resolution of discrimination-related grievances.[29] MCP discrimination grievance procedures must follow the requirements outlined in sections III (A) – (C) of APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, or any superseding APL, including timely acknowledgment and resolution of discrimination grievances. Members are not required to file a discrimination grievance with the MCP before filing a discrimination grievance directly with DHCS OCR or the HHS OCR.[30]

[25] The physical notice must be in a conspicuous location and easily readable by a member of the public (for example, in a patient waiting area), not behind private office doors.
[26] WIC 14029.91(f)
[27] WIC 14029.91(e)(1)-(5); GOV 11135
[28] WIC 14029.91(e)(4); 45 CFR 84.7; 34 CFR 106.8; 28 CFR 35.107; California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B. See also Gov. Code 11135.
[29] See, e.g., 45 CFR 84.7; 34 CFR 106.8; 28 CFR 35.107.
[30] WIC 14029.91(e)(4)-(5)

The MCP's discrimination grievance coordinator must be available to:

1. Answer questions and provide appropriate assistance to MCP staff and members regarding the MCP's state and federal nondiscrimination legal obligations.
2. Advise the MCP about nondiscrimination best practices and accommodating persons with disabilities.
3. Investigate and process any ADA, section 504, section 1557, and/or Government Code section 11135 grievances received by the MCP.

MCPs must ensure that all discrimination grievances are investigated by the MCP's designated discrimination grievance coordinator.[31] MCPs are prohibited from using a medical peer review body to investigate and resolve discrimination grievances. MCPs must not claim that a discrimination grievance investigation or resolution is confidential under Evidence Code section 1157 and/or Business and Professions Code section 805. Concurrent or subsequent referral of a discrimination grievance to a peer review body for provider disciplinary or credentialing purposes may be appropriate if quality of care issues are implicated, or if required by the MCP contract.

The MCP contract requires MCPs to forward copies of all member grievances alleging discrimination on the basis of any characteristic protected by federal or state nondiscrimination law to DHCS. This includes, without limitation, sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56. This requirement includes language access complaints and complaints alleging failure to make reasonable accommodations under the ADA.

Within ten calendar days of mailing a discrimination grievance resolution letter to a member, MCPs must submit detailed information regarding the grievance to DHCS OCR's designated discrimination grievance email box. MCPs must submit the following information in a secure format to DHCS.DiscriminationGrievances@dhcs.ca.gov:

1. The original complaint;
2. The provider's or other accused party's response to the grievance;
3. Contact information for the MCP personnel responsible for the MCP's investigation and response to the grievance;
4. Contact information for the member filing the grievance and for the provider or other accused party that is the subject of the grievance;

[31] See, e.g., 45 CFR 84.7; 34 CFR 106.8; 28 CFR 35.107.

5. All correspondence with the member regarding the grievance, including the grievance acknowledgment and grievance resolution letter(s) sent to the member; and
6. The results of the MCP's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

Language Assistance Taglines
DHCS determined the tagline requirements in this APL based on a combination of federal and state law and DHCS policy. MCPs are required to post taglines in a conspicuously visible font size (no less than 12-point font), in English and the top California languages as identified below in this APL and in the DHCS provided taglines template that is attached to this APL.[32] These taglines inform members, potential enrollees, and the public of the availability of no-cost language assistance services, including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities.[33]

Like the nondiscrimination notice, these taglines must be posted in the Member Handbook/Evidence of Coverage, conspicuous physical locations where the MCP interacts with the public, on the MCP's website in a location that allows any visitor to the website to easily locate the information, and in all member information and other informational notices, in accordance with federal and state law and this APL.[34]

MCPs are not prohibited from including taglines in languages that exceed those identified for California in this APL.

In 2016, HHS OCR released a Frequently Asked Questions (FAQ) document and included as a resource a table displaying its list of the top 15 languages spoken by individuals with LEP in each state, the District of Columbia, Puerto Rico and each U.S. Territory. HHS OCR created this list for use in identifying languages in which to provide translated taglines. The top 15 non-English languages spoken by LEP individuals in California, as identified by HHS OCR in 2016, are Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Punjabi, Russian, Spanish, Tagalog,

[32] WIC 14029.91(a)(3) requires that these taglines be provided in at least the top 15 languages spoken by LEP individuals in the state; however, DHCS requires MCPs to provide these taglines in English, the top 15 non-English languages spoken by LEP individuals in the state, and Laotian, Ukrainian, and Mien.
[33] 42 CFR 438.10(d)(2)-(3)
[34] WIC 14029.91(f)

Thai, and Vietnamese.[35] Although state law only requires that taglines be provided in the top 15 non-English languages in California, DHCS made a policy decision to align the MCP required tagline languages with those used in Medi-Cal FFS for consistency between programs. As a result, in addition to the top 15 non-English languages spoken by LEP individuals in California, as identified by HHS OCR in 2016, MCPs must also provide taglines in Laotian, Ukrainian and Mien (i.e.; English and 18 non-English languages).

Language Assistance Services
Language assistance services must be provided free of charge, be accurate and timely, and protect the privacy and independence of the LEP individual. There are two primary types of language assistance services: oral and written. LEP individuals are not required to accept language assistance services, although a qualified interpreter may be used to assist in communicating with an LEP individual who has refused language assistance services.[36]

Oral Interpretation
MCPs must provide oral interpretation services from a qualified interpreter (see qualifications below), on a 24-hour basis, at all key points of contact,[37] at no cost to members.[38] Oral interpretation must be provided in all languages and is not limited to threshold or concentration standard languages.

Interpretation can take place in-person, through a telephonic interpreter, or via internet or video remote interpreting (VRI) services. However, MCPs are prohibited from using remote audio or VRI services that do not comply with federal quality standards,[39] or relying on unqualified bilingual/multilingual staff, interpreters, or translators. MCPs should not solely rely on telephone language lines for interpreter services. Rather, telephonic interpreter services should supplement face-to-face interpreter services, which are a more effective means of communication.

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[35] For more information about the HHS OCR language table and the data used, please refer to the HHS OCR FAQ. The FAQ can be accessed at: https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/top15-languages/index.html. The language table can be accessed at: https://www.hhs.gov/sites/default/files/resources-for-covered-entities-top-15-languages-list.pdf.
[36] See 45 CFR 92.101(c)
[37] Per the MCP contract, key points of contact include medical care settings (e.g., telephone, advice and urgent care transactions, and outpatient encounters with health care providers, including pharmacists) and non-medical care settings (e.g., member services, orientations, and appointment scheduling).
[38] WIC 14029.91(a) and 42 CFR 438.10(d)(2) and (d)(4)
[39] See 45 CFR 92.101(b)(3)(iii); 45 CFR 92.102; 28 CFR 35.160(d); and 28 CFR 36.303(f).

An interpreter is a person who renders a message spoken in one language into one or more languages. An interpreter must be qualified and have knowledge in both languages of the relevant terms or concepts particular to the program or activity and the dialect spoken by the LEP individual. In order to be considered a qualified interpreter for an LEP individual, the interpreter must: 1) have demonstrated proficiency in speaking and understanding both English and the language spoken by the LEP individual; 2) be able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary, terminology, and phraseology; and 3) adhere to generally accepted interpreter ethics principles, including client confidentiality.[40]

MCPs that provide a qualified interpreter for an individual with LEP through remote audio interpreting services must provide real-time audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality audio without lags or irregular pauses in communication; a clear, audible transmission of voices; and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the remote interpreting services.[41]

MCPs are prohibited from requiring LEP individuals to provide their own interpreters, or from relying on bilingual/multilingual staff members who do not meet the qualifications of a qualified interpreter.[42] Some bilingual/multilingual staff may be able to communicate effectively in a non-English language when communicating information directly in that language, but may not be competent to interpret in and out of English. Bilingual/multilingual staff may be used to communicate directly with LEP individuals only when they have demonstrated to the MCP that they meet all of the qualifications of a qualified interpreter listed above.[43]

Further, the use of family members, friends, and particularly minor children as interpreters may compromise communications with LEP individuals. LEP individuals may be reluctant to reveal personal and confidential information in front of these individuals. In addition, family members, friends, and minor children may not be trained in interpretation skills and may lack familiarity with specialized terminology. As a result, use of such persons could result in inaccurate or incomplete communications, a breach of the LEP individual's confidentiality, or reluctance on the part of the LEP individual to reveal critical information. MCPs are prohibited from relying on an adult or minor child

[40] WIC 14029.91(a) and 45 CFR 92.101(b)(3)
[41] 45 CFR 92.101(b)(3)(iii)
[42] WIC 14029.91(a)(1)(C) and CFR 92.101(b)(4)
[43] WIC 14029.91(a)(1)(C)

accompanying an LEP individual to interpret or facilitate communication except when: 1) there is an emergency involving an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is not immediately available; or, 2) the LEP individual specifically requests that an accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.[44] Prior to using a family member, friend or, in an emergency only, a minor child as an interpreter for an LEP individual, MCPs must first inform the individual that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the LEP individual's confidentiality. MCPs must also ensure that the LEP individual's refusal of free interpreter services and their request to use family members, friends, or a minor child as an interpreter is documented in the medical record.

Written Translation

Translation is the replacement of written text from one language into another. MCPs must use a qualified translator when translating written content in paper or electronic form.[45] A qualified translator is a translator who: 1) adheres to generally accepted translator ethics principles, including client confidentiality; 2) has demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and, 3) is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.[46] At a minimum, MCPs must provide written translations of member information in the threshold and concentration languages identified in this APL in the DHCS Threshold and Concentration Language Requirements section. In that same section of this APL, DHCS has also provided an explanation of the information that is considered "member information" for purposes of this requirement.

Effective Communication with Individuals with Disabilities

MCPs must comply with all applicable requirements of federal and state disability law.[47] MCPs are required to take appropriate steps to ensure effective communication with individuals with disabilities.[48] MCPs must provide appropriate auxiliary aids and services

[44] WIC 14029.91(a)(1)(D) and 45 CFR 92.101(b)(4)
[45] 45 CFR 92.101(b)(3)(ii)
[46] 45 CFR 92.101(b)(3)(ii)
[47] Without limitation, MCPs must comply with Section 1557 of the ACA, Title II of the ADA, Section 504 of the Rehabilitation Act, and GOV 11135.
[48] 45 CFR 92.102(a); 28 CFR 35.160-35.164

to persons with impaired sensory, manual, or speaking skills,[49] including the provision of qualified interpreters and written materials in alternative formats, free of charge and in a timely manner, when such aids and services are necessary to ensure that individuals with disabilities have an equal opportunity to participate in, or enjoy the benefits of, the MCP's services, programs, and activities.[50] Without limitation, MCPs must provide interpretive services and make member information available in the following alternative formats: Braille, audio format, large print (no less than 20 point font), and accessible electronic format (such as a data CD). In determining what types of auxiliary aids and services are necessary, MCPs must give "primary consideration" to the individual's request of a particular auxiliary aid or service.[51] DHCS' expectation is that MCPs collect and store members' alternative format selections. DHCS is currently working on finalizing the necessary data elements that will be required for regular reporting of this information to DHCS. At this time, we are requesting that MCPs begin tracking and recording the Beneficiary Client Index Number, name, date of request, and requested alternative format. DHCS will provide further guidance on the process for submitting the alternative format data in the near future. DHCS is also working on a process that will allow DHCS to share information with the MCPs that the department collects as well.

Auxiliary aids and services include:

- Qualified interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.
- Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20 point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.[52]

[49] 45 CFR 92.102(b)
[50] 28 CFR 35.160; 45 CFR 92.102
[51] 28 CFR 35.160
[52] 45 CFR 92.102(b)(1)

When providing interpretive services, MCPs must use qualified interpreters to interpret for an individual with a disability, whether through a remote interpreting service or an on-site appearance. A qualified interpreter for an individual with a disability is an interpreter who: 1) adheres to generally accepted interpreter ethics principals, including client confidentiality; and 2) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.[53] For an individual with a disability, qualified interpreters can include, for example, sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

MCPs that provide a qualified interpreter for an individual with a disability through VRI services must provide real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position; a clear, audible transmission of voices; and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.[54]

MCPs must not require an individual with a disability to provide their own interpreter. Moreover, MCPs are prohibited from relying on an adult or minor child accompanying an individual with a disability to interpret or facilitate communication except when: 1) there is an emergency involving an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is not immediately available; or, 2) the individual with a disability specifically requests that an accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.[55] Prior to using a family member, friend, or, in an emergency only, a minor child as an interpreter for an individual with a disability, MCPs must first inform the individual that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the individual’s confidentiality. MCPs must also ensure that the refusal of free interpreter services and the individual's request to use a family member, friend, or a minor child as an interpreter is documented in the medical record.

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[53] 45 CFR 92.102(b)(2)
[54] 28 CFR 35.160(d); 28 CFR 36.303(f); 45 CFR 92.102
[55] 28 CFR 35.160(c) 28 CFR 36.303(c)

In addition to requiring effective communication with individuals with disabilities, HHS OCR regulations pursuant to Section 1557 incorporate other long-standing requirements of federal law prohibiting discrimination based on disability.[56] MCPs are reminded that they must make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination based on disability. This could include, for example, assisting a member who cannot write to fill out required forms, even when such assistance is not generally provided to members without a disability.

Policies and Procedures

Within 180 days of the release of this APL, MCPs must submit policies and procedures demonstrating their compliance with the ADA, Section 504 of the Rehabilitation Act, Section 1557, including the implementing federal regulations, SB 223/SB 1423, and GOV 11135, and must update and resubmit these policies and procedures to DHCS following any substantive change in federal or state nondiscrimination law. MCP policies and procedures must ensure that, upon a substantive change in federal or state nondiscrimination law, training regarding the change will be incorporated into one or more appropriate existing, regularly scheduled MCP staff trainings.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all subcontractors and network providers.

If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[56] 45 CFR. 92.103-92.105

Policy:	GG.1607Δ
Title:	**Monitoring Adverse Actions**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	12/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and/or other entities against CalOptima Practitioners or Organizational Providers (OPs).

II. POLICY

A. CalOptima and its Health Networks shall perform ongoing monitoring of a Practitioner or OPs sanctions, complaints, adverse actions, and quality issues between recredentialing cycles.

B. Adverse actions include, but are not limited to, the following:

1. Any adverse action by the Medical Board of California, or the appropriate licensing board/agency, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 with the Medical Board of California or the appropriate licensing board/agency and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. ~~Any~~An action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. ~~Any~~An action taken by the California Department of Public Health, Division of Licensing and Certification;

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8. ~~Any~~An action taken by the Health and Human Services Office of the Inspector General (OIG~~);~~) including placement on the List of Excluded Individuals/Entities (LEIE);

~~9. Any~~An action taken by System for Award Management (SAM~~); or~~

9. ~~Any~~) to list a provider ~~listed~~ as debarred, excluded or otherwise ineligible to contract;

10. Placement of the provider on the CMS Preclusion List;

11. Placement of the provider on the Medi-Cal Procedure/Drug Code Limitation List;

12. Adding the provider to the Department of Health Care Service (DHCS) Restricted Provider Database (RPD);

13. Confirmation that the provider is listed as active on the National Plan and Provider Enumeration System (NPPES);

14. Placement of the provider on the DHCS Suspended and Ineligible Provider List; or

~~10.~~15. Placement of the provider on the Medicare Opt-Out List.

C. CalOptima shall refer information of adverse actions taken against CalOptima Practitioners or OPs to CalOptima's Quality Improvement Department and Medical Director for review and referral to the Credentialing Peer Review Committee (CPRC) for consideration as part of the quality review process at re-credentialing and between credentialing cycles.

D. Adverse actions that impact a provider's participation in federal or state health care programs, including, but not limited to, debarments, suspension, and exclusion will be immediately referred to CalOptima's Regulatory Affairs & Compliance Department for evaluation of potential compliance actions (*e.g.*, overpayment refunds) in accordance with CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring.

III. PROCEDURE

A. CalOptima monitors Practitioners and OPs on an ongoing basis to identify adverse actions that may affect participation in CalOptima ~~program.~~ programs.

B. CalOptima monitors various state and federal boards, agencies, and databanks for adverse actions including:

1. OIG exclusion list: upon credentialing and recredentialing and ongoing on a monthly basis;

2. SAM list: upon credentialing and recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01 reports upon credentialing and recredentialing, and continuous monitoring through NPDB reports~~;~~ as updates are released;

4. Medicare Opt-Out Physicians: upon credentialing and recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon credentialing and recredentialing and ongoing on a monthly basis;

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions;

7. California State Licensing Boards for all Practitioners within FACETS~~;~~; upon credentialing and recredentialing and checked monthly and quarterly as reports are published;

8. CMS Preclusion List as published by CMS~~,~~: upon credentialing and recredentialing~~,~~ and ongoing on a monthly basis~~.~~;

9. Medi-Cal Procedure/Drug Code Limitation List: upon credentialing and recredentialing and on a monthly basis; and

10. DHCS Restricted Provider Database (RPD) on a monthly basis.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse actions identified through ongoing monitoring shall be tracked and as appropriate, communicated via Provider Alert to the CalOptima Medical Director, Provider Relations, Health Network Relations, and Provider Data Management Systems (PDMS) Departments.

E. Upon credentialing and recredentialing, adverse actions identified in the tracking database will be summarized and added to the Practitioner and OP file.

F. The QI Department shall report, in a confidential manner, all adverse action findings to the CPRC.

G. CalOptima shall also monitor and consider internal quality data (e.g~~.~~., potential quality issues (PQIs), and ~~member grievances~~Member Grievances) between recredentialing cycles as in accordance with CalOptima Policies GG.1611: Potential Quality Issue Review Process, CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: Member Grievance, MA.9002: Member Grievance Process.

H. The QI Department shall forward all Practitioner and OP potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

I. CalOptima shall inform affected Practitioners or OPs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

J. CalOptima's Quality Improvement Department shall maintain credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files and shall ensure that all Credentialing files are up to date.

K. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) business days of final notification to CalOptima.

1. The report to DHCS shall include the following:

   a. Contract status (by delegated entity, if applicable) with the named provider.

   b. The number of ~~members~~Members receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

L. Any actions that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENT(S)

A. Ongoing Monitoring Website Information Matrix

V. REFERENCE(S)

~~A. California Business and Professions Code, §§805 and 805.01~~
~~B.~~A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy CMC.9001: Member Complaint Process
F. CalOptima Policy CMC.9002: Member Grievance Process
G. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima ~~Providers~~Provider Information, CalOptima Providers Directory, and Web-based Directory~~.~~
H. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
I. CalOptima Policy GG.1611: Potential Quality Issue Review Process
J. CalOptima Policy GG.1615: Corrective Action Plan for Practitioners
K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy HH.1101: CalOptima Provider Complaint
M. CalOptima Policy HH.1102: Member ~~-~~Grievance
N. CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring
O. CalOptima Policy MA.9002: Member Grievance Process
P. CalOptima Policy MA.9006: Provider Complaint Process
~~Q.~~A. ~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~R.~~Q. Department of Health Care Services All Plan Letter ~~16-001~~21-003: Medi-Cal Network Provider and ~~Subcontract Suspensions,~~Subcontractor Terminations ~~and Decertifications~~
R. Department of Health Care Services All Plan Letter 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment
S. Title 42 United States Code §11101 et seq.
T. California Welfare and Institutions Code, §14044
U. California Business and Professions Code, §§805 and 805.01

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/04/2017	Department of Health Care Services (DHCS)	Approved as Submitted
03/25/2020	Department of Health Care Services (DHCS)	Approved as Submitted
09/23/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
11/29/2018	Regular Meeting of the CalOptima Credentialing Peer Review Committee
02/12/2019	Regular Meeting of the CalOptima Quality Improvement Committee
09/18/2019	Regular Meeting of the CalOptima Quality Assurance Committee
10/03/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/01/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Retired	02/01/2013	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE
Revised	10/03/2019	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE
Revised	04/01/2020	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Behavioral Health Providers	For purposes of this policy, a licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
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.
Long Term Support Services (LTSS) Providers	For purposes of this policy, A licensed practitioner such as physicians, NMP's, social workers, and nurse managers
Member	A beneficiary enrolled in a CalOptima program.
Non-Physician Medical Practitioner (NMP)	Med-Cal: A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.

Term	Definition
	PACE: Means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.
Organizational Providers (OPs)	Medi-Cal: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. OneCare ~~/&~~ OneCare Connect: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility , nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
~~Non-Physician Medical Practitioner (NMP)~~	~~Means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.~~
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), Licensed Midwife (LM) 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.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

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Policy:	GG.1607Δ
Title:	**Monitoring Adverse Actions**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	12/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and/or other entities against CalOptima Practitioners or Organizational Providers (OPs).

II. POLICY

A. CalOptima and its Health Networks shall perform ongoing monitoring of a Practitioner or OPs sanctions, complaints, adverse actions, and quality issues between recredentialing cycles.

B. Adverse actions include, but are not limited to, the following:

1. Any adverse action by the Medical Board of California, or the appropriate licensing board/agency, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 with the Medical Board of California or the appropriate licensing board/agency and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. An action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. An action taken by the California Department of Public Health, Division of Licensing and Certification;

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8. An action taken by the Health and Human Services Office of the Inspector General (OIG) including placement on the List of Excluded Individuals/Entities (LEIE);

9. An action taken by System for Award Management (SAM) to list a provider as debarred, excluded or otherwise ineligible to contract;

10. Placement of the provider on the CMS Preclusion List;

11. Placement of the provider on the Medi-Cal Procedure/Drug Code Limitation List;

12. Adding the provider to the Department of Health Care Service (DHCS) Restricted Provider Database (RPD);

13. Confirmation that the provider is listed as active on the National Plan and Provider Enumeration System (NPPES);

14. Placement of the provider on the DHCS Suspended and Ineligible Provider List; or

15. Placement of the provider on the Medicare Opt-Out List.

C. CalOptima shall refer information of adverse actions taken against CalOptima Practitioners or OPs to CalOptima's Quality Improvement Department and Medical Director for review and referral to the Credentialing Peer Review Committee (CPRC) for consideration as part of the quality review process at re-credentialing and between credentialing cycles.

D. Adverse actions that impact a provider's participation in federal or state health care programs, including, but not limited to, debarments, suspension, and exclusion will be immediately referred to CalOptima's Regulatory Affairs & Compliance Department for evaluation of potential compliance actions (*e.g.*, overpayment refunds) in accordance with CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring.

III. PROCEDURE

A. CalOptima monitors Practitioners and OPs on an ongoing basis to identify adverse actions that may affect participation in CalOptima programs.

B. CalOptima monitors various state and federal boards, agencies, and databanks for adverse actions including:

1. OIG exclusion list: upon credentialing and recredentialing and ongoing on a monthly basis;

2. SAM list: upon credentialing and recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01 reports upon credentialing and recredentialing, and continuous monitoring through NPDB reports as updates are released;

4. Medicare Opt-Out Physicians: upon credentialing and recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon credentialing and recredentialing and ongoing on a monthly basis;

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions;

7. California State Licensing Boards for all Practitioners within FACETS: upon credentialing and recredentialing and checked monthly and quarterly as reports are published;

8. CMS Preclusion List as published by CMS: upon credentialing and recredentialing and ongoing on a monthly basis;

9. Medi-Cal Procedure/Drug Code Limitation List: upon credentialing and recredentialing and on a monthly basis; and

10. DHCS Restricted Provider Database (RPD) on a monthly basis.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse actions identified through ongoing monitoring shall be tracked and as appropriate, communicated via Provider Alert to the CalOptima Medical Director, Provider Relations, Health Network Relations, and Provider Data Management Systems (PDMS) Departments.

E. Upon credentialing and recredentialing, adverse actions identified in the tracking database will be summarized and added to the Practitioner and OP file.

F. The QI Department shall report, in a confidential manner, all adverse action findings to the CPRC.

G. CalOptima shall also monitor and consider internal quality data (e.g., potential quality issues (PQIs), and Member Grievances) between recredentialing cycles as in accordance with CalOptima Policies GG.1611: Potential Quality Issue Review Process, CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: Member Grievance, MA.9002: Member Grievance Process.

H. The QI Department shall forward all Practitioner and OP potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

I. CalOptima shall inform affected Practitioners or OPs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

J. CalOptima's Quality Improvement Department shall maintain credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files and shall ensure that all Credentialing files are up to date.

K. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) business days of final notification to CalOptima.

1. The report to DHCS shall include the following:

a. Contract status (by delegated entity, if applicable) with the named provider.

b. The number of Members receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

L. Any actions that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENT(S)

A. Ongoing Monitoring Website Information Matrix

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy CMC.9001: Member Complaint Process
F. CalOptima Policy CMC.9002: Member Grievance Process
G. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima Provider Information, CalOptima Providers Directory, and Web-based Directory
H. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
I. CalOptima Policy GG.1611: Potential Quality Issue Review Process
J. CalOptima Policy GG.1615: Corrective Action Plan for Practitioners
K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy HH.1101: CalOptima Provider Complaint
M. CalOptima Policy HH.1102: Member Grievance
N. CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring
O. CalOptima Policy MA.9002: Member Grievance Process
P. CalOptima Policy MA.9006: Provider Complaint Process
Q. Department of Health Care Services All Plan Letter 21-003: Medi-Cal Network Provider and Subcontractor Terminations
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Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
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Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
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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), Licensed Midwife (LM) 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.
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Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

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Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 6332322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	~~www.mbc.ca.gov~~https://search.dca.ca.gov/ **All communications for disciplinary actions will be done by e-mail to subscribers.** ~~Link to subscribe for actions: http://www.mbc.ca.gov/Subscribers/~~ ~~Link for all Disciplinary Actions/License Alerts distributed: http://www.mbc.ca.gov/Publications/Disciplinary_Actions/~~	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final.

Ongoing Monitoring Website Information

Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov	DO	**https://search.dca.ca.gov/** ~~**www.ombc.ca.gov**~~ **Direct Link t~~T~~o Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	Quarterly via the Website E-Mail Distribution list.~~:~~

Ongoing Monitoring Website Information

Medical Board of California Board of Podiatric Medicine 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651	DPM	https://search.dca.ca.gov/ ~~www.bpm.ca.gov~~ ~~Direct Link toEnforcement Resources: http://www.bpm.ca.gov/consumers/index.shtml~~ ~~Subscribers list http://www.mbc.ca.gov/Subscrib ers/~~ -	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. varies/ check monthly
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204	LAC/AC	https://search.dca.ca.gov/ www.acupuncture.ca.gov ~~Direct Link to Disciplinary Actions: www.acupuncture.ca.gov/consumers/board_actions.shtml~~	Monthly ~~running report listed Alpha~~ ~~Newer actions highlighted with date in blue.~~

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**https://search.dca.ca.gov/** ~~**www.bbs.ca.gov**~~	Via Subscriptions Only Information must be obtained via subscription. Monthly
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**https://search.dca.ca.gov/** ~~**www.chiro.ca.gov**~~ ~~**Monthly Reports**~~ ~~**http://www.chiro.ca.gov/enforcement/actions.shtml**~~	Monthly

Ongoing Monitoring Website Information

Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov	DDS, DMD	https://search.dca.ca.gov/ ~~www.dbc.ca.gov~~ ~~Direct Link to Disciplinary Actions:~~ ~~http://www.dbc.ca.gov/consumers/hotsheets.shtml~~	Monthly

Ongoing Monitoring Website Information

California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701	OT, OTA	https://search.dca.ca.gov/ www.bot.ca.gov ~~Direct Link To Enforcement Actions:~~ ~~http://www.bot.ca.gov/consumers/disciplinary_action.shtml~~	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	https://search.dca.ca.gov/ ~~www.optometry.ca.gov~~ ~~Direct Link To Enforcement Actions:~~ ~~http://www.optometry.ca.gov/consumers/disciplinary.shtml~~	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Monthly review.

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	https://search.dca.ca.gov/ ~~www.ptb.ca.gov~~	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners. Emails are sent monthly
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	https://search.dca.ca.gov/ ~~www.pac.ca.gov~~ ~~Direct Link To Enforcement Actions:~~ ~~www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml~~	Monthly
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-5033221.**	PhD, PsyD	https://search.dca.ca.gov/ ~~www.psychboard.ca.gov~~	**Via Subscriptions Only** Information must be obtained via subscription. Varies Monthly

Ongoing Monitoring Website Information

CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**https://search.dca.ca.gov/** ~~**www.rn.ca.gov**~~ ~~**Unlicensed Practice/Nurse Imposter Citations:**~~ ~~**http://www.rn.ca.gov/enforcement/unlicprac.shtml**~~	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

Ongoing Monitoring Website Information

Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**https://search.dca.ca.gov/** **http://www.speechandhearing.ca.gov/** Direct Link to Accusations Pending and Disciplinary Actions: **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml**	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal HealthFederal Health Care Programs: Medicare /Medicaid sanction & exclusions	**www.oig.hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/**	**Monthly**

Ongoing Monitoring Website Information

CMS.gov Centers for Medicare & Medicaid Services	Medicare Opt-Out Affidavits. Effective 1/29/18	**https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Op t-Out-Affidavits/7yuw-754z**	**Quarterly**
CMS.gov Centers for Medicare & Medicaid Services	The CMS Preclusion List Effective 1/01/19	CMS made ~~will make~~ the initial Preclusion List available to Plans ~~beginning January 1, 2019~~ on a secure website and updates are ~~will be~~ made available approximately every 30 days, on the 25th business day of each month. ~~around the first business day of each month.~~ ~~Details on how it will be distributed to Quality Improvement is TBD.~~	**Monthly and Upon Initial and Recredentialing Cycle.**

Ongoing Monitoring Website Information

Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **Direct Link to Suspended and Ineligible Provider List**: **http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp**	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/**	**Monthly via Lexis Nexis Monitoring**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	~~**www.deadiversion.usdoj.gov/**~~ **Direct Link to Validation Form** **https://www.cms.gov/Medicare/Provider-Enrollment-**	**Monthly via Lexis Nexis Monitoring**

Ongoing Monitoring Website Information

		andCertification/MedicareProvider SupEnroll/OptOutAffidavits.html ~~https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp~~	
Terrorist Watch List/Office of Foreign Assets Control	Practitioner & Medical Groups	https://sanctionssearch.ofac.treas.gov/	~~Weekly~~Monthly
Drug Code Limitation	Listing of practitioners and/or medical groups placed on P/DCL sanction	https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	Monthly
Department of Health Care Service (DHCS)- Restricted Provider Database	Practitioners, Medical Groups, Pharmacy	Effective 3/2020 started reviewing restricted provider list.	Monthly

Additional Websites for Initial and Recredentialing Verifications

Site ~~Name, Address~~Name, Address and Phone Numbers	Service	Website	Instructions and Comments
~~The Licensed Facility Information system (LFIS)~~ ~~The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California.~~ ~~The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health~~	~~Organizational Providers License Verification:~~ ~~Hospitals~~ ~~Long-term care facilities~~ ~~Home Health Agencies~~ ~~Hospices~~ ~~Primary care and Specialty clinics~~	~~www.alirts.oshpd.ca.gov/Default.aspx~~ ~~Direct Link:~~ ~~www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx~~	~~The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at:~~ ~~www.dhs.ca.gov/LNC/default.htm~~ ~~To search for a facility~~ ~~• Enter name in box that is found in top right corner~~ Search or ~~• Link to Advance Search on the left under Login.~~ ~~LFIS Home~~ ~~Alirts Home~~ ~~Advanced Search~~ ~~You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.~~

Additional Websites for Initial and Recredentialing Verifications

~~agencies and hospices.~~			

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Additional Websites for Initial and Recredentialing Verifications

The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Ambulatory Surgery Centers Home Health Agencies Hospices Dialysis Centers ~~Others~~ Community Based Adult Services (CBAS) Skilled Nursing Facilities Federal Qualified Health Centers (FQHC)	~~http://www.cdph.ca.gov/Pages/DEFAULT.aspx~~ ~~Licensed Facility Report~~ ~~http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing~~ ~~Health Facilities Search~~ ~~http://hfcis.cdph.ca.gov/search.aspx~~ ~~https://www.cdph.ca.gov/~~	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 **Revised 3/10/2020, Revised 6/14/2021, 7/30/2021**

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Additional Websites for Initial and Recredentialing Verifications

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

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Additional Websites for Initial and Recredentialing Verifications

National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an **Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

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Additional Websites for Initial and Recredentialing Verifications

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses ~~**American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017)**~~ ~~*(Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)*~~ ~~Center (ANCC)~~ ~~National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties(ncc)~~ ~~Pediatric Nursing Certification Board (PNCB)~~ ~~American Association of Critical-Care Nurses (AACN)~~	NP	**American Academy of Nurse Practitioners Certification Board (AANPCB)** – www.aanpcert.org/ **American Nursing Credentialing Center (ANCC)** –www.nursecredentialing.org **National Nursing Credentialing Center (NCC)** ~~ncc –~~ www.nccwebsite.org **Pediatric Nursing Certification Board(PNCB)** –www.pncb.org **American Association of Critical Care Nurses (AACN)**	Informational only to verify board certification	**Board Certification**

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

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Additional Websites for Initial and Recredentialing Verifications

		-www.aacn.org		
National Commission on Certification of PA's (NCCPA)	PAC	https://portal.nccpa.net/verifypac~~http://www.nccpa.net/~~	Informational only to verify board certification	**Board Certification**

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

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Additional Websites for Initial and Recredentialing Verifications

American Midwifery Certification Board **(AMCB~~amcb~~)** 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	http://www.amcbmidwife.org/	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed
~~**Board Certification, Address and Phone Numbers**~~	~~**Practitioner Types**~~	~~**Website**~~	~~**Instructions and Comments**~~	~~**Verification Type**~~
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 -Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	http://www.abpp.org/	Under Find a Board Certified Psychologists □ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed

Additional Websites for Initial and Recredentialing Verifications

Three specialty certifying boards are currently approved under California law for DPM: **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)~~).~~ **The American Board of Podiatric Medicine** (Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine **American Board of Multiple Specialties in Podiatry.** (~~-~~Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	American Board of Foot and Ankle Surgery. https://www.abfas.org/ The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**
National Practitioner Data Bank-NPDB	NPDB	**NPDB** https://www.npdb.hrsa.gov/		

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

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Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California 2005 Evergreen Street Suite 1200 Sacramento CA 95815 PH: (916) 263-2382 or 1 (800) 633-2322 **Enforcement Central File Room** PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord: PH: (916) 263-2449	MD	**https://search.dca.ca.gov/** **All communications for disciplinary actions will be done by e-mail to subscribers.**	Bi-monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final.

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Osteopathic Medical Board of CA 1300 National Drive Suite 150 Sacramento CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax Email: osteopathic@dca.ca.gov	DO	**https://search.dca.ca.gov/** **Direct Link to Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	Quarterly via the website Email distribution list.

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California Board of Podiatric Medicine 2005 Evergreen Street Suite 1300 Sacramento CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651	DPM	**https://search.dca.ca.gov/**	Board of Podiatric Medicine: Changes to viewing information on the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. varies/ **check Monthly**
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204	LAC/AC	**https://search.dca.ca.gov/**	**Monthly**

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd Suite S-200 Sacramento CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**https://search.dca.ca.gov/**	Via Subscriptions Only Information must be obtained via subscription. **Monthly**
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street Suite 142A Sacramento CA 95814 PH: (916) 263-5355 FAX: (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**https://search.dca.ca.gov/**	**Monthly**

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Dental Board of California 2005 Evergreen Street Suite 1550 Sacramento CA 95815 PH: (916) 263-2300 PH Toll Free: 1 (877) 729-7789 Fax: (916) 263-2140 Email: dentalboard@dca.ca.gov	DDS, DMD	**https://search.dca.ca.gov/**	**Monthly**

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701	OT, OTA	https://search.dca.ca.gov/	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. Email Submission

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
California State Board of Optometry 2450 Del Paso Road Suite 105 Sacramento CA 95834 PH: (916) 575-7170 Fax: (916) 575-7292 Email: optometry@dca.ca.gov	OD	**https://search.dca.ca.gov/**	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. **Monthly review.**

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**https://search.dca.ca.gov/**	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners. Emails are sent monthly

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento CA 95815 PH: (916) 561-8780 FAX: (916) 263-2671 Email: pacommittee@mbc.ca.gov	PA/PAC	**https://search.dca.ca.gov/**	**Monthly**
Board of Psychology 1625 North Market Blvd Suite N-215 Sacramento CA 95834 PH: (916)-574-7720 **PH Toll Free: 1 (866) 503-3221** Email: bopmail@dca.ca.gov	PhD, PsyD	**https://search.dca.ca.gov/**	**Via Subscriptions Only** Information must be obtained via subscription. **Varies Monthly**
CA Board of Registered Nursing 1747 North Market Blvd Suite 150 Sacramento CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse	**https://search.dca.ca.gov/**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Sacramento CA 94244-2100 PH: (916) 322-3350 FAX: (916) 574-7693 Email: enforcement_brn@dca.ca.gov	(CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)		
Speech-Language Pathology & Audiology Board 2005 Evergreen Street Suite 2100 Sacramento CA 95815 PH: (916) 263-2666 Fax: (916) 263-2668 Email: speechandhearing@dca.ca.gov	SP, AU	**https://search.dca.ca.gov/**	**Quarterly** Disciplinary Actions are listed by fiscal year.
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore MD 21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaid sanction & exclusions	**Direct Link for individuals:** **http://exclusions.oig.hhs.gov/**	**Monthly**

Revised 05/01/2018, Revised 12/21/2018, Revised 1/11/2019, Revised 1/24/2020, Revised 3/10/2020, Revised 6/14/2021, Revised 7/26/2021, Revised 11/5/2021
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Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
CMS.gov Centers for Medicare & Medicaid Services	Medicare Opt-Out Affidavits. Effective 1/29/18	**https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	**Quarterly**
CMS.gov Centers for Medicare & Medicaid Services	The CMS Preclusion List Effective 1/01/19	CMS made the initial Preclusion List available to Plans on a secure website and updates are made available approximately every 30 days, on the 25th business day of each month.	**Monthly and Upon Initial and Recredentialing Cycle.**

Ongoing Monitoring Website Information

Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd Baltimore MD 21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **Direct Link to Suspended and Ineligible Provider List**: **http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp**	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.c om/**	**Monthly via Lexis Nexis Monitoring**
DEA Office of Diversion Control **1 (800) 882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**Direct Link to Validation Form** **https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html**	**Monthly via Lexis Nexis Monitoring**

Ongoing Monitoring Website Information

Terrorist Watch List/Office of Foreign Assets Control	**Practitioner & Medical Groups**	**https://sanctionssearch.ofac.treas.gov/**	**Monthly**
Drug Code Limitation	**Listing of practitioners and/or medical groups placed on P/DCL sanction**	**https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx**	**Monthly**
Department of Health Care Service (DHCS)- Restricted Provider Database	**Practitioners, Medical Groups, Pharmacy**	Effective 3/2020 started reviewing restricted provider list.	**Monthly**

Additional Websites for Initial and Recredentialing Verifications

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The California Department of Public Health (CDPH) General Information PH: (916) 558-1784	**Organizational Providers License Verification:** Hospitals Ambulatory Surgery Centers Home Health Agencies Hospices Dialysis Centers Community Based Adult Services (CBAS) Skilled Nursing Facilities Federal Qualified Health Centers (FQHC)	https://www.cdph.ca.gov/	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Additional Websites for Initial and Recredentialing Verifications

National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo ND 58108-6059 PH Toll Free: 1 (800) 465-3203 Email: customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an **Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

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Additional Websites for Initial and Recredentialing Verifications

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses	NP	**American Academy of Nurse Practitioners Certification Board (AANPCB)** www.aanpcert.org/ **American Nursing Credentialing Center (ANCC)** www.nursecredentialing.org **National Nursing Credentialing Center (NCC)** www.nccwebsite.org **Pediatric Nursing Certification Board(PNCB)** www.pncb.org **American Association of Critical Care Nurses (AACN)** www.aacn.org	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**https://portal.nccpa.net/verifypac**	Informational only to verify board certification	**Board Certification**

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

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Additional Websites for Initial and Recredentialing Verifications

American Midwifery Certification Board (AMCB) 849 International Drive Suite 120 Linthicum MD 21090 PH: (410) 694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification • Click Search button • Enter last Name, First Name and Certification Number • Click Search Button	**Board Certification** Informational only to verify board certification needed
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill NC 27516 PH: (919) 537-8031 Email: Office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists □ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed

Additional Websites for Initial and Recredentialing Verifications

Three specialty certifying boards are currently approved under California law for DPM: **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA) **The American Board of Podiatric Medicine** (Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	American Board of Foot and Ankle Surgery. https://www.abfas.org/ The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**
National Practitioner Data Bank-NPDB	NPDB	**NPDB** https://www.npdb.hrsa.gov/		

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: **June 12, 2019**

ALL PLAN LETTER 19-004
SUPERSEDES ALL PLAN 17-019

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F, dated May 6, 2016.[1] Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 of the Code of Federal Regulations (CFR), Section 438.214.[2] The screening and enrollment responsibilities are located in Part 1 and the credentialing and recredentialing responsibilities are located in Part 2 of this APL. This APL supersedes APL 17-019.[3]

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act.[4] The intent of Title 42 of the CFR, Part 455, Subparts B and E was to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.[5]

The Final Rule extended the provider screening and enrollment requirements of Title 42 of the CFR, Part 455, Subparts B and E to MCP network providers. These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

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[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[2] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=ed7b5cfe19321ccc382dbc8dbfef17cb&mc=true&node=pt42.4.438&rgn=div5
[3] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] 42 CFR, Part 455 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

MCPs are required to maintain contracts with their network providers (Network Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal program. Title 42 of the CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, aligning with the FFS enrollment requirements described in Title 42 of the CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards. The Medi-Cal managed care program and MCPs must comply with statewide Medi-Cal FFS enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway.[6] The 21st Century Cures Act (Cures Act) required managed care network provider enrollment to be implemented by January 1, 2018.[7]

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[8] Credentialing is defined as the recognition of professional or technical competence.[9] The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Welfare and Institutions Code (WIC), Sections 14043 through 14045. WIC, Sections 14043 through 14045 are available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=1.3.
[7] Title 42 of the United States Code (USC), Section 1396u-2(d)(6)(A). The USC is searchable at: http://uscode.house.gov/
[8] MCP Contract, Exhibit A, Attachment 4, Credentialing and Recredentialing. MCP contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[9] MCP Contract, Exhibit A, Attachment 1, Definitions.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCP network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program.[10, 11] State-level enrollment pathways are available either through the Department of Health Care Services' (DHCS) Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.[12] MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or MCPs may direct their network providers to enroll through a state-level enrollment pathway. DHCS' PED is the primary developer of state-level enrollment pathways for FFS providers. If an MCP chooses to enroll a provider type into their network that does not have an enrollment pathway through PED, DHCS will recognize all other state-level enrollment pathways.

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers.[13] MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through a state-level enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP cannot participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through a state-level enrollment pathway. For providers who are

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[10] "Network provider" is defined in 42 CFR, Section 438.2, available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=1b74655ecc02b0de9edb16df3de9284e&ty=HTML&h=L&mc=true&r=SECTION&n=se40.32.438_12

[11] More information on network provider status is available in APL19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status.

[12] For a complete list of state-level enrollment pathways, refer to the resource listing on the PED Frequently Asked Questions (FAQ) webpage, available at: https://www.dhcs.ca.gov/provgovpart/Pages/PEDFrequentlyAskedQuestions.aspx

[13] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

typically required to enroll but are restricted due to a moratorium, MCPs must develop their own enrollment pathway if the MCP chooses to include them in their network.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis. Additionally, pursuant to the July 24, 2018, CMS Medicaid Provider Enrollment Compendium (MPEC), MCPs will no longer be required to enroll providers that do not have a state-level enrollment pathway.[14] Additionally, DHCS will only process provider applications that have a state-level enrollment pathway established by DHCS' PED[15]; therefore, applications submitted to DHCS from providers that do not have a state-level enrollment pathway through PED will be denied. MCPs who choose to enroll these providers must do so through their own established enrollment process, through the recognized enrollment process developed by another MCP, or, if applicable, through a state-level enrollment pathway established by another state department.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[16] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and completeness. MCPs must ensure that all information specified in Title 22 of the California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments of the application package, are received.[17] As part of the application process, the MCP must obtain the provider's consent to allow DHCS and the MCP to share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.

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[14] The MPEC is available at: https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf

[15] More information on PED's enrollment process and pathways is available at: https://www.dhcs.ca.gov/provgovpart/pages/pave.aspx

[16] Application packages by provider type can be found at the following: https://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types, see 22 CCR, Sections 51000 – 51000.26 and 51051.

[17] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[18] Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. Medi-Cal Provider Agreement and Network Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state as a condition of participating in the Medi-Cal program.[19, 20] As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the Medi-Cal Provider Agreement (DHCS Form 6208).[21] This provider agreement is separate and distinct from the Network Provider Agreement (see below). MCPs must maintain the original signed Medi-Cal Provider Agreement for each provider. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and location that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Network Provider Agreement) is separate and distinct from the Medi-Cal Provider Agreement. Both the Medi-Cal Provider Agreement and the Network Provider Agreement are required for MCP network providers. The Medi-Cal Provider Agreement does not expand or alter the MCP's existing rights or obligations relating to its Network Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42 of the CFR, Sections 455.104, 455.105, and 455.106, and Title 22 of the CCR, Section 51000.35. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information described in Title 42 of the CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42 of the CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal program. These disclosures must be provided when:

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[18] For more information on DHCS' current application fee, see the "Latest News" section of the PED homepage, available at: https://www.dhcs.ca.gov/provgovpart/pages/ped.aspx
[19] Social Security Act (SSA), Section 1902(a)(27). SSA, Section 1902 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm
[20] WIC, Section 14043.1(c).
[21] The Medi-Cal Provider Agreement (DHCS Form 6208) and other relevant forms related to provider agreement requirements are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

- A prospective provider submits the provider enrollment application.
- A provider executes the Medi-Cal Provider Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[22]

Additionally, MCPs must comply with the requirements contained in Title 22 of the CCR, Section 51000.35. MCPs are not required to utilize the DHCS disclosure forms (DHCS Forms 6207 and 6216); however, MCPs must collect all information and documentation required by Title 22 of the CCR, Section 51000.35.

D. Limited, Moderate, and High Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as limited, moderate, or high. If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening and for MCPs to stratify their network providers by risk level are set forth in Attachment A of this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs must not enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements;

[22] 42 CFR, Section 455.105(b)

- Hold a license certified for practice in the state and has no limitations from other states; and
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers

- Screening requirements of limited-risk providers; and
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers; and
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

Providers are categorized as high-risk if that provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.[23, 24]

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers – Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a 5%

[23] 42 CFR, Section 455.450(e)(2)
[24] WIC, Section 14043.38(b)(4)

or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[25] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. MCPs must direct providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website.[26] MCPs must ensure providers include the correct agency information on the Live Scan form when submitting their application to the California DOJ so their application is processed correctly. The agency-specific information must be included in the appropriate fields as detailed below:

Applicant Submission

Field	Entry
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	Entry
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or P.O. Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

[25] WIC, Section 14043.38(c)
[26] The Live Scan form is available on Forms for Applicant Agencies webpage on the DOJ website, available at: https://oag.ca.gov/fingerprints/forms.

When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider shall deliver the completed Live Scan form to the California DOJ. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of the criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22 of the CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. MCPs must conduct post-enrollment site visits for medium-risk network providers at least every five years, and their high-risk network providers every three years or as necessary. Post-enrollment onsite visits verify that the information submitted to the MCP and DHCS is accurate, and to determine if providers are in compliance with state and federal enrollment requirements. In addition, all providers enrolled in the Medi-Cal program, including providers enrolled through MCPs, are subject to unannounced onsite inspections at all provider locations.[27]

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[27] 42 CFR, Section 455.432

G. Federal and State Database Checks

During the provider enrollment/reenrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:[28]

- Social Security Administration's Death Master File.[29]
- National Plan and Provider Enumeration System (NPPES).[30]
- List of Excluded Individuals/Entities (LEIE).[31]
- System for Award Management (SAM).[32]
- CMS' Medicare Exclusion Database (MED).[33]
- DHCS' Suspended and Ineligible Provider List.[34]
- Restricted Provider Database (RPD).[35]

In addition to checking all the databases upon a provider's enrollment/reenrollment, MCPs must also review the SAM, LEIE, and RPD databases on a monthly basis. All databases must be reviewed upon a provider's enrollment/reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the MCP's provider network.

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal managed care program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment that may impact the provider's eligibility to participate in the Medi-Cal program, or a provider refuses to submit to the required screening activities, the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal program.[36]

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[28] 42 CFR, Section 455.436
[29] Information on requesting access to the Social Security Administration's Death Master File is available at: https://www.ssa.gov/dataexchange/request_dmf.html
[30] NPPES is available at: https://nppes.cms.hhs.gov
[31] LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp
[32] SAM is available at: https://www.sam.gov/SAM/
[33] An overview of MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html. The MED database is the source that is used to populate the LEIE list. MCPs can use the LEIE if they are not able to access MED.
[34] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[35] The Restricted Provider Database is available at: https://eportal.dhcs.ca.gov/dhcs/ai-rp. For information on gaining access to the database, refer to the FAQ included with this APL.
[36] 42 CFR, Section 455.416

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If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[37]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[38]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement in Attachment B of this APL, which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment B. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through DHCS' Medi-Cal FFS provider enrollment process.

[37] Provider enrollment information can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx
[38] 42 CFR, Section 455.422

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- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment
To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their network providers at least every five years.[39] MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[40] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process.[41]

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

[39] 42 CFR, Section 455.414
[40] 42 CFR, Section 438.3(u)
[41] 42 CFR, Section 438.602(b)(2)

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Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements
MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing
MCPs are required to verify the credentials of their network providers, and to verify the following items, as required for the particular provider type, through a primary source,[42] as applicable:[43]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.

[42] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[43] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.

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- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[44]
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the MCP's provider network.
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

MCPs are required to credential all contracted providers that render services to assigned members, whether the providers have a state-level FFS enrollment pathway or not, in accordance with state and federal law.

Attestations

For all network providers types who deliver Medi-Cal covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[45]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities all serious quality deficiencies that result in the suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including

[44] National Practitioner Data Bank is available at: https://www.npdb.hrsa.gov/
[45] For more information, see Policy Letter (PL) 02-003, or any future iterations of this PL. PLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx

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reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites.[46] MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization. The MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. However, MCPs retain overall responsibility for ensuring that credentialing requirements are met.

[46] For more information, see PL 14-004, and any future iterations of this PL.

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Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Attachments

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Attachment A
Provider Types and Categories of Risk[47]

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or the NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or the NASDAQ is considered "limited" risk
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered "limited" risk
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Non-public, non-government owned or affiliated ambulance services suppliers
  - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered "limited" risk.

(3) High Risk Provider Types. Characteristics and provider types:

[47] The CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations is available at: https://www.govinfo.gov/content/pkg/FR-2011-02-02/pdf/2011-1686.pdf

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- Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS
- Providers prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months
- Diabetes Prevention Program (DPP) providers

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Attachment B
Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that managed care providers that have a state-level FFS enrollment pathway must enroll in the Medi-Cal program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal program. Providers may enroll through either (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements: (1) the Network Provider Agreement and (2) the Medi-Cal Provider Agreement. The Network Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The Medi-Cal Provider Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. **Enrollment through an MCP.** The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

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application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal an MCP's decision to cease the enrollment process
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' PED for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS. The following provides information on DHCS' enrollment process:

- DHCS' Provider Enrollment page and the Provider Enrollment information on DHCS' website will be updated to reflect that PED is no longer accepting paper applications for provider types supported in the Provider Application and Validation for Enrollment (PAVE) portal. There will be links per provider type that will guide applicants to PAVE. For those provider not yet fully migrated into PAVE, the provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program until such time that the application is migrated into PAVE processing.[48]
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

[48] For more information, see the "Application Packages by Provider Type" webpage on the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)

Medi-Cal Procedure/Drug Code Limitation Introduction

Page updated: August 2020

In accordance with SB 857 and Welfare and Institutions Code (W&I Code), Section 14044, a Procedure/ Drug Code Limitation (P/DCL) may be imposed on a provider's use of one or more codes (CPT®, NDC or HCPCS) for a period of up to 18 months, if one of the following conditions exists:

- The Department of Health Care Services (DHCS) determines, by audit or other investigation, that excessive services, billings or abuse have occurred by a provider
- A provider's licensing authority or a court of competent jurisdiction limits a licensee's practice of medicine, where the limitation precludes the licensee from performing services that could otherwise be reimbursed

A provider placed on P/DCL sanction will not be able to receive reimbursement for those services under restriction. In addition, providers who fill orders for lab tests, drugs, medical supplies or any other restricted services prescribed or ordered by a provider under restriction will not be reimbursed.

The limitation becomes effective after DHCS gives the provider notice of the proposed limitation, and no appeal is submitted within 45 days or following the denial of an appeal.

DHCS reviews provider appeal evidence and issues the appeal decision within 45 days of receipt. If the appeal is not granted, the code-use limitations become effective 15 days after provider notification.

In a situation where the sanction could interfere with the provider's or other prescriber's ability to render health care services to a recipient, the burden to transfer the recipient's care to another qualified provider remains the responsibility of the provider.

The P/DCL may be used separately or in tandem with other existing anti-fraud and abuse efforts.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table. ››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.››

Policy:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with ~~Title 42, Code of Federal Regulations, Section 422.204(a) and other~~ applicable laws, regulations, and regulatory guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network or other Delegate in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of Credentialing applications.

1. A Health Network or Delegate shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities shall include but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving provider files, and ensuring credentialing policies are adhered to.

D. The CalOptima CPRC shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall credential and recredential the following Practitioners as provided in this Policy: Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use

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Disorder (SUD) Practitioners, and Long-Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, certified, or registered by the state of California to practice independently;

2. Contracted with CalOptima to provide care under CalOptima's programs (including those Practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services); and

3. Who provide care to Members under the organization's medical benefits.

F. Credentialing and recredentialing shall apply to Practitioners meeting the criteria in Section II.E. of this Policy, regardless of whether they provide care:

1. In individual or group practices;

2. In facilities; or

3. Through telemedicine/telehealth i.e., virtual care visit.

G. CalOptima shall credential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and do not have an independent relationship with CalOptima including:

1. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP; or

2. NMPs who provide services as part of an Organized ~~health~~Health Care System that is credentialed with CalOptima and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

3. NMPs who are not PAs and who provide services under the employment agreement of a credentialed Provider.

H. An NMP shall notify CalOptima immediately if the supervising Physician Practitioner no longer meets the CalOptima Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity or Organized Health System.

I. CalOptima does not credential or recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates Utilization Management (UM) functions (Credentialing of Pharmacies and its professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406~~:~~Δ: Pharmacy Network Credentialing and Access);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima; and

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer).

J. CalOptima shall ensure that any provider for whose provider type has an enrollment pathway with Department of Health Care Services (DHCS) is enrolled with DHCS as a provider in accordance with DHCS All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described in Sections III.A. and III.B. of this Policy.

K. CalOptima shall recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

L. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall monitor various state, federal, boards, agencies and databanks for adverse activities in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse ~~Activities.~~Actions.

M. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within thirty (30) calendar days of the date of the decision of the reason(s) for the denial.

N. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

O. CalOptima shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

P. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

Q. CalOptima shall monitor and prevent discriminatory Credentialing decisions as provided in this Policy.

R. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

S. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

T. CalOptima shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the credentialing committee.

U. If CalOptima is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

V. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

W. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

   a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify that the Physician Practitioner meets the minimum standards as provided in that Policy.

   c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima that attests to:

      i. Any work history gap that exceeds six (6) months, including written clarification;

      ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

      iii. Lack of present illegal drug use that impairs current ability to practice;

      iv. History of criminal convictions;

      v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

      vi. Current malpractice insurance coverage; and

      vii. The correctness and completeness of the application;

   d. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

e. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

g. An NMP, other than a PA, who does not have an individual relationship with CalOptima, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Provider.

h. A PA who does not have an individual relationship with CalOptima, and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Provider; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision;

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

3. CalOptima shall also collect and verify the following information from each Provider as applicable but need not verify this information through a primary source. (see Attachment B). This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

c. Any alternative admitting arrangements must be documented in the Credentialing file;

d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

e. A valid National Provider Identifier (NPI) number;

f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision~~:~~. For Behavioral Health Services Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision.

g. Practitioner information entered in the National Practitioner Data Bank (NPDB), if applicable;

h. No exclusion, preclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

i. A review of any Grievances, or quality cases, filed against a Practitioner in the last five (5) years;

j. No exclusion or preclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion or preclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

   i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

   ii. A felony conviction related to neglect, or abuse, of patients in connection with the delivery of a health care item, or service;

   iii. A felony conviction related to health care fraud; or

   iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. History of state sanctions, restrictions on licensure or limitations on scope of practice;

m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

n. Full or provisional California Children's Services (CCS)-paneled approval status, with a current active panel status;

~~o.~~ Current IRS Form W-9;

~~p.~~o.

~~q.~~p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews;

~~r.~~q. Active enrollment status with Medi-Cal, as required; and

~~s.~~r. ~~Absence from the~~Active enrollment status with Medicare ~~Preclusion List~~ for OneCare ~~and~~or OneCare Connect ~~Practitioners.~~ as required (i.e., has not Opted-Out of Medicare program).

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

   a. Collect and verify, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this Policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the Practitioner; and

   b. Incorporate the following data in the decision-making process, which shall have been reviewed no more than one hundred eighty (180) calendar days before the Recredentialing decision is made.

      i. Member Grievances and Appeals, including number and type during the past three (3) years;

      ii. Information from quality review activities;

      iii. Board Certification, if applicable;

      iv. Member satisfaction, if applicable;

      v. Medical Record Reviews, if applicable;

      vi. FSR results and PARS results, if applicable; and

      vii. Compliance with the terms of the Practitioner's contract.

   c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial Credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner rights included in the Addendum A of the credentialing application, as follows:

   a. Right to review information

      i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

   b. Right to correct erroneous information

      i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

      ii. All Practitioners have the right to correct erroneous information, as follows:

         a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

         b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

         c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

            Attention: Quality Improvement Department – Credentialing
            CalOptima
            505 City Parkway West
            Orange, CA 92868

      iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

   a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

   a. Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.

   b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

   c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing and Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files and determining the Practitioner's participation in CalOptima programs.

3. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

   a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than $25,000 paid by, or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review

      i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

      ii. ~~Approved, clean~~Clean file lists approved by a Medical Director shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

   b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include more than one (1) malpractice claim that resulted in ~~settlements~~a settlement or ~~judgments~~judgment greater than $25,000, or NPDB query identifying Medical Board investigations, or other actions.

      i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

      ii. CPRC shall give thoughtful consideration to the information presented in the credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may ~~-~~take place in real-time, or as a virtual meeting via telephone or video conference, but may not be conducted through e-mail.

4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process and shall be verified prior to making a Credentialing decision.

a. The Quality Improvement Department shall send the Practitioner a decision letter, within thirty (30) calendar days of the decision~~:~~ indicating:

i. Acceptance;

ii. Acceptance with restrictions along with Appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or

iii. Denial of the application along with Appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

1. Monitoring

a. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

b. Review Practitioner complaints to determine if there are complaints alleging discrimination.

c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

2. Prevention

a. The QI Department shall maintain a heterogeneous credentialing committee and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. This Provider profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e., education, training, Board Certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online provider directory.

IV. ATTACHMENT(S)

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
C. Council for Affordable Quality Healthcare Provider Application (CAQH)
D. HIV/AIDS Specialist Designation
E. Attestation Questions
F. Addendum A Practitioner Rights

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima PACE Program Agreements
E. CalOptima Contract for Health Care Services
F. NCQA Standards and Guidelines
G. CalOptima Policy GG.1406~~:~~Δ: Pharmacy Network: Credentialing and Access
H. CalOptima Policy GG.1602~~:~~Δ: Non-Physician Medical Practitioner (NMP) Scope of Practice
I. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
J. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Policy GG.1607Δ: Monitoring Adverse ~~Activities~~Actions
L. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
M. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
N. CalOptima Policy GG.1619: Delegation Oversight
O. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
P. CalOptima Policy GG.1643Δ: Minimum Physician Standards
Q. CalOptima Policy GG.1651Δ: ~~Credentialing and Recredentialing of a Healthcare Delivery Organization (HDO)~~Assessment and Re-Assessment of Organizational Providers
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy MA.9006: Provider Complaint Process
T. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
V. Department of Health Care Services All Plan Letter (APL) ~~18-023~~21-005: California Children's Services Whole Child Model Program
W. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
X. Title 42, Code of Federal Regulations, ~~§~~Part 455, Subpart E
Y. Title 42, United States Code, §1320a-7(a)
Z. Title XVIII and XIV of the Social Security Act
AA. California Business and Professions Code, §805 and §§3500-3502.3
BB. California Evidence Code, §1157
CC. Medicare Managed Care Manual, Chapter 6: Relationships with Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/01/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/01/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/01/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal
Retired	02/01/2015	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Retired	03/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A ~~request~~review by CalOptima of an adverse benefit determination, which includes one of the ~~member~~following actions: 1. A denial or limited authorization of a requested service, including determinations based on the ~~member's Authorized Representative~~type or level of service, requirements for ~~review of any decision to deny, modify, or discontinue~~Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service~~.~~; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), sections 41515.2 through 41518.9.
California Children's Services (CCS~~))-~~ Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
Continuity of Care	Medi-Cal & OneCare Connect: Services provided to a ~~member~~Member rendered by an out-of-network provider with whom the ~~member~~Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and ~~4.~~6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization	For purposes of this policy, an organization that collects and verifies credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
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.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.

Term	Definition
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume specialist physician offices.
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	~~A Grievance is an~~ Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination~~.~~ under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances ~~may~~ include, but are not limited to, the quality of care or services provided~~,~~ and aspects of interpersonal relationships such as rudeness of a ~~provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision.~~ Provider or employee, or failure to respect the Member's rights). Also~~,~~ called a "Complaint ~~from a Member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code~~." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section ~~14450 and California Health and Safety Code Section 1368 and 1368.1.~~460.120.
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.
Long Term Support Services (LTSS) Provider	For purposes of this policy, a licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.

Term	Definition
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed 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), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502 of the Business and Professions Code and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to members by referral by other than a Primary Care Provider (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

Term	Definition
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.

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Policy:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network or other Delegate in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of Credentialing applications.

1. A Health Network or Delegate shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities shall include but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving provider files, and ensuring credentialing policies are adhered to.

D. The CalOptima CPRC shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall credential and recredential the following Practitioners as provided in this Policy: Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use

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Disorder (SUD) Practitioners, and Long-Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, certified, or registered by the state of California to practice independently;

2. Contracted with CalOptima to provide care under CalOptima's programs (including those Practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services); and

3. Who provide care to Members under the organization's medical benefits.

F. Credentialing and recredentialing shall apply to Practitioners meeting the criteria in Section II.E. of this Policy, regardless of whether they provide care:

1. In individual or group practices;

2. In facilities; or

3. Through telemedicine/telehealth i.e., virtual care visit.

G. CalOptima shall credential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and do not have an independent relationship with CalOptima including:

1. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP; or

2. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

3. NMPs who are not PAs and who provide services under the employment agreement of a credentialed Provider.

H. An NMP shall notify CalOptima immediately if the supervising Physician Practitioner no longer meets the CalOptima Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity or Organized Health System.

I. CalOptima does not credential or recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates Utilization Management (UM) functions (Credentialing of Pharmacies and its professional and

technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406Δ: Pharmacy Network Credentialing and Access);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima; and

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer).

J. CalOptima shall ensure that any provider for whose provider type has an enrollment pathway with Department of Health Care Services (DHCS) is enrolled with DHCS as a provider in accordance with DHCS All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described in Sections III.A. and III.B. of this Policy.

K. CalOptima shall recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

L. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall monitor various state, federal, boards, agencies and databanks for adverse activities in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.

M. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within thirty (30) calendar days of the date of the decision of the reason(s) for the denial.

N. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

O. CalOptima shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

P. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

Q. CalOptima shall monitor and prevent discriminatory Credentialing decisions as provided in this Policy.

R. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

S. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

T. CalOptima shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the credentialing committee.

U. If CalOptima is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

V. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

W. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

   a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify that the Physician Practitioner meets the minimum standards as provided in that Policy.

   c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima that attests to:

      i. Any work history gap that exceeds six (6) months, including written clarification;

      ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

      iii. Lack of present illegal drug use that impairs current ability to practice;

      iv. History of criminal convictions;

      v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

      vi. Current malpractice insurance coverage; and

      vii. The correctness and completeness of the application;

d. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.
e. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

g. An NMP, other than a PA, who does not have an individual relationship with CalOptima, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Provider.

h. A PA who does not have an individual relationship with CalOptima, and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima; stating the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Provider; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision;

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

3. CalOptima shall also collect and verify the following information from each Provider as applicable but need not verify this information through a primary source (see Attachment B). This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;
c. Any alternative admitting arrangements must be documented in the Credentialing file;

d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

e. A valid National Provider Identifier (NPI) number;

f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision. For Behavioral Health Services Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision.

g. Practitioner information entered in the National Practitioner Data Bank (NPDB), if applicable;

h. No exclusion, preclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

i. A review of any Grievances, or quality cases, filed against a Practitioner in the last five (5) years;

j. No exclusion or preclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion or preclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

   i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

   ii. A felony conviction related to neglect, or abuse, of patients in connection with the delivery of a health care item, or service;

   iii. A felony conviction related to health care fraud; or

   iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. History of state sanctions, restrictions on licensure or limitations on scope of practice;

m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

n. Full or provisional California Children's Services (CCS)-paneled approval status, with a current active panel status;

o. Current IRS Form W-9;

p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews;

q. Active enrollment status with Medi-Cal, as required; and

r. Active enrollment status with Medicare for OneCare or OneCare Connect as required (i.e., has not Opted-Out of Medicare program).

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

a. Collect and verify, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this Policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the Practitioner; and

b. Incorporate the following data in the decision-making process, which shall have been reviewed no more than one hundred eighty (180) calendar days before the Recredentialing decision is made.

i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. Information from quality review activities;

iii. Board Certification, if applicable;

iv. Member satisfaction, if applicable;

v. Medical Record Reviews, if applicable;

vi. FSR results and PARS results, if applicable; and

vii. Compliance with the terms of the Practitioner's contract.

c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial Credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner rights included in the Addendum A of the credentialing application, as follows:

   a. Right to review information

      i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

   b. Right to correct erroneous information

      i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

      ii. All Practitioners have the right to correct erroneous information, as follows:

         a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

         b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

         c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

            Attention: Quality Improvement Department – Credentialing
            CalOptima
            505 City Parkway West
            Orange, CA 92868

      iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

   a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

    a. Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.

    b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

    c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing and Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files and determining the Practitioner's participation in CalOptima programs.

3. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

    a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than $25,000 paid by, or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review

        i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

        ii. Clean file lists approved by a Medical Director shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

    b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than $25,000, or NPDB query identifying Medical Board investigations, or other actions.

        i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

        ii. CPRC shall give thoughtful consideration to the information presented in the credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may take place in real-time, or as a virtual meeting via telephone or video conference, but may not be conducted through e-mail.

4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process and shall be verified prior to making a Credentialing decision.

a. The Quality Improvement Department shall send the Practitioner a decision letter, within thirty (30) calendar days of the decision indicating:

i. Acceptance;

ii. Acceptance with restrictions along with Appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or

iii. Denial of the application along with Appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

1. Monitoring

a. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

b. Review Practitioner complaints to determine if there are complaints alleging discrimination.

c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

2. Prevention

a. The QI Department shall maintain a heterogeneous credentialing committee and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. This Provider profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e., education, training, Board Certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online provider directory.

IV. ATTACHMENT(S)

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
C. Council for Affordable Quality Healthcare Provider Application (CAQH)
D. HIV/AIDS Specialist Designation
E. Attestation Questions
F. Addendum A Practitioner Rights

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima PACE Program Agreements
E. CalOptima Contract for Health Care Services
F. NCQA Standards and Guidelines
G. CalOptima Policy GG.1406Δ: Pharmacy Network: Credentialing and Access
H. CalOptima Policy GG.1602Δ: Non-Physician Medical Practitioner (NMP) Scope of Practice
I. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
J. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Policy GG.1607Δ: Monitoring Adverse Actions
L. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
M. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
N. CalOptima Policy GG.1619: Delegation Oversight
O. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
P. CalOptima Policy GG.1643Δ: Minimum Physician Standards
Q. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy MA.9006: Provider Complaint Process
T. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
V. Department of Health Care Services All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program
W. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
X. Title 42, Code of Federal Regulations, Part 455, Subpart E
Y. Title 42, United States Code, §1320a-7(a)
Z. Title XVIII and XIV of the Social Security Act
AA. California Business and Professions Code, §805 and §§3500-3502.3
BB. California Evidence Code, §1157
CC. Medicare Managed Care Manual, Chapter 6: Relationships with Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response

04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/01/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/01/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/01/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal
Retired	02/01/2015	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Retired	03/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), sections 41515.2 through 41518.9.

Term	Definition
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
Continuity of Care	Medi-Cal & OneCare Connect: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization	For purposes of this policy, an organization that collects and verifies credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
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.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume specialist physician offices.
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.

Term	Definition
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
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.
Long Term Support Services (LTSS) Provider	For purposes of this policy, a licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	A beneficiary enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.

Term	Definition
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed 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), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502 of the Business and Professions Code and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to members by referral by other than a Primary Care Provider (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

Term	Definition
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.

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California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

Last Name: First Name: Middle:

Is there any other name under which you have been known? Name(s):

Home Mailing Address:

City: State: Zip Code:

Home Phone Number: ( ) - Fax Number: ( ) - Cell Number: ( ) - Pager Number: ( ) -

Practitioner Email: Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):

Birth Date: Social Security Number: - -

Birth Place: Gender Male Female

Driver's License State/Number: Race/Ethnicity (optional):

Your intent is to serve as a(n):

Primary Care Provider Specialist Urgent Care Hospitalist Hospital Based

Specialty:

Subspecialties:

III. Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Primary Office Address:

City: State: Zip Code:

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number: ( ) -

Office Administrator/Manager Email: Office Administrator/Manager Fax Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

III. Practice Information (Continued)

Please identify the physical accessibility of this office. ○ Basic ○ Limited ○ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

please type the working days and the working hours

Primary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #:

Group NPI #:

Secondary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Secondary Office Address:

City: State: Zip Code: -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

Please identify the physical accessibility of this office. ○ Basic ○ Limited ○ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Secondary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Tertiary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Tertiary Office Address:

City: State: Zip Code: -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number: ( ) -

Office Administrator/Manager Email: Office Administrator/Manager Fax Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Tertiary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Mailing Address

Which of your practices is your primary mailing address? ◯ Primary ◯ Secondary ◯ Tertiary ◯ Other

If your mailing address is different from your practice address, please provide it:

IV. Billing Information

Which of your practices handles your billing? ◯ Primary ◯ Secondary ◯ Tertiary If none, please provide billing information:

Billing Company

Billing Company Mailing Address:

City: State: Zip Code: -

Contact Person: Telephone Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

V. Practice Description

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ◯ Yes ◯ No
If so, please list:

Name	Type of Provider	License Number

Physician Assistant Supervisor Name: License Number:

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ◯ Yes ◯ No
If so, please list:

Name	California Medical License Number	Primary/Secondary/Tertiary Practice
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you perform that are not typically associated with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Is your practice limited to certain ages? ◯ Yes ◯ No If yes, specify limitation:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company

Answering Service Mailing Address:

City: State: Zip Code: - Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

VI. Education, Training and Experience

Medical/Professional Education

Medical School/Professional: | Degree Received: | Graduation Date:

Mailing Address: | Website (if applicable):

City: | State: | Zip Code: - | Registrar's Phone Number: ( ) -

Internship/PGY-1

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Internship: | From (mm/yyyy): | To (mm/yyyy):

Did you successfully complete the program? ◯ Yes ◯ No (If No, please explain on a separate sheet.)

Residencies/Fellowships

Include residencies, fellowships, and postgraduate education in chronological order. Use a separate sheet if necessary.

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ☒ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

VII. Medical Licensure & Certifications

California State Medical License Number	Issue Date	Expiration Date

Drug Enforcement Agency (DEA) Registration Number	Schedules	Expiration Date

Controlled Dangerous Substances Certificate (CDS) (if applicable)	Expiration Date

ECFMG Number (applicable to foreign medical graduates)	Issue Date

Individual National Physician Identifier (NPI)	Medi-Cal/Medicaid Number	Individual Medicare PTAN Number

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? ◯ Yes ◯ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:

Board Name:

Exam Date:

Describe here:

VIII. Current Hospital and Other Institutional Affiliations

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Primary Hospital Address:

City: State: Zip Code: - From (mm/yy):

Medical Staff Phone: ( ) - Medical Staff Fax: ( ) - To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Secondary Hospital Address:

City: State: Zip Code: - From (mm/yy):

Medical Staff Phone: ( ) - Medical Staff Fax: ( ) - To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: - From (mm/yy):

Medical Staff Phone: ( ) - Medical Staff Fax: ( ) - To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: - From (mm/yy):

Medical Staff Phone: ( ) - Medical Staff Fax: ( ) - To (mm/yy):

A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):

B. Previous Hospital and Other Institution Affiliations

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

IX. Peer References

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference: Specialty:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

X. Work History

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. Curriculum vitae are not sufficient. Please explain any gaps on a separate page.

Current Practice: Contact Name:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

XI. Professional Liability

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

XII. Professional and Practice Services

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? Yes No

What type of anesthesia do you provide in your group/office?

Local Regional Conscious Sedation General None Other (please specify)

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID: Type of Service Provided: Do you have a CLIA certificate? Yes No

Billing Name: Do you have a CLIA waiver? Yes No

CLIA Certificate Number: CLIA Certificate Expiration Date:

XII. Professional and Practice Services (continued)

Have you or your office received any of the following accreditations, certificates or licensures?

- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☐ Child Health and Disability Prevention Program (CHDP)
- ☐ Comprehensive Perinatal Services Program (CPSP)
- ☐ California Children Services (CCS)
- ☐ Family Planning
- ☐ Other

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ○ Yes ○ No If so, which Network?

Do you use a practice management system/software? ○ Yes ○ No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ◯ Yes ◯ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ◯ Yes ◯ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ◯ Yes ◯ No

15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ◯ Yes ◯ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable) | **PRINTED NAME** | **DATE**

Continue to the Next Page for Information Release/ Acknowledgements

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable) | **PRINTED NAME** | **DATE**

Addenda Submitting :

☐ Addendum B: Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages (pages 15 and 16) before submission.

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:	505 City Parkway West				
City:	Orange	ST:	CA	Zip:	92868

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖

PRINTED NAME ✖

DATE ✖

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I. Practioner Identifying Information

Last Name: _____ First Name: _____ Middle: _____

II. Case Information

Patient's Name: _____ Patient Gender ◯ Male ◯ Female Patient DOB: _____

City, County, State where lawsuit filed: _____ Court Case number, if known: _____ Date of alleged incident serving as basis for the lawsuit/ arbitration: _____ Date suit filed: _____

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) _____

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) _____

Allegation

_____

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ◯ Yes ◯ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Telephone Number: ( ) - Fax Number: ( ) -

III. Status of Lawsuit/Arbitration (check one)

- ☐ Lawsuit/arbitration still ongoing, unresolved.
- ☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____
- ☐ Judgment rendered and I was found not liable.
- ☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____
- ☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖ **PRINTED NAME** ✖ **DATE** ✖

CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Verification
MD – Medical Board of California	https://search.dca.ca.gov/ https://www.mbc.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Department of Consumer Affairs; Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – DEA

DEA	Source of Verification	Method of Verification
	https://www.deadiversion.usdoj.gov/ https://apps.deadiversion.usdoj.gov/webforms2/spring/timedout.xhtml	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database.

CalOptima Primary Source Verification Table

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification
~~Board Certification~~	~~https://www.boardcertifieddocs.com/~~	~~Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~
	~~https://www.aoaprofiles.org/~~ ~~American Board of Podiatric Surgery~~	~~Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~
Board Certification	American Board of Medical Specialties https://certifacts.abms.org/~~https://www.abms.org/~~	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Professional Psychology https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated
	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources

		are electronically tracked and dated.
Nursing Board	**Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses** American Academy of Nurse Practitioners Certification Board (AANPCB) www.aanpcert.org/ American Nursing Credentialing Center (ANCC) https://www.nursingworld.org/ancc/ National Certification Corporation (NCC) www.nccwebsite.org Pediatric Nursing Certification Board (PNCB) www.pncb.org American Association of Critical Care Nurses (AACN) www.aacn.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Commission on Certification of PA's (NCCPA) https://portal.nccpa.net/verifypac	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Education & Training

Education	Source of Verification	Method of Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are

		electronically tracked and dated.
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Contact the training institution to verify the highest level of training; or State Licensing Agency, as applicable.	Letter from institution is reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Student Clearing House http://nscverifications.org/welcome-to-verification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Board of Physicians and Surgeons (NBPAS) https://nbpas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Primary Source Verification Table

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification
Malpractice History	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification –Sanctions and other sources

Sanction Information	Source of Verification	Method of Verification
State & Federal Sanctions and Other Sources	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=true~~https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf~~	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Medi-Cal Suspended & Ineligible List https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Drug Code Limitation Listing of practitioners and/or medical groups placed on P/DCL sanction,	Verified sources are reviewed and stored in Credentialing database. All sources are

	https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	electronically tracked and dated.
	Department of Health Care Service (DHCS)- Restricted Provider Database	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS.gov Centers for Medicare & Medicaid Services – Medicare Opt-Out Physicians https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html For a listing of all physicians and practitioners that are currently opted out of Medicare: https://data.cms.gov/tools/provider-opt-out-affidavits-look-up-tool	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Other Sanction Sources	AMA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Verification
MD – Medical Board of California	https://search.dca.ca.gov/ https://www.mbc.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Department of Consumer Affairs; Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – DEA

DEA	Source of Verification	Method of Verification
	https://www.deadiversion.usdoj.gov/ https://apps.deadiversion.usdoj.gov/webforms2/spring/timedout.xhtml	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database.

CalOptima Primary Source Verification Table

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification
Board Certification	American Board of Medical Specialties https://certifacts.abms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Professional Psychology https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated
	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Nursing Board	**Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses** American Academy of Nurse Practitioners Certification Board (AANPCB) www.aanpcert.org/ American Nursing Credentialing Center (ANCC) https://www.nursingworld.org/ancc/ National Certification Corporation (NCC) www.nccwebsite.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

	Pediatric Nursing Certification Board (PNCB) www.pncb.org American Association of Critical Care Nurses (AACN) www.aacn.org	
	National Commission on Certification of PA's (NCCPA) https://portal.nccpa.net/verifypac	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Education & Training

Education	Source of Verification	Method of Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Contact the training institution to verify the highest level of training; or	Letter from institution is reviewed and stored in

	State Licensing Agency, as applicable.	Credentialing database. All sources are electronically tracked and dated.
	National Student Clearing House http://nscverifications.org/welcome-to-verification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Board of Physicians and Surgeons (NBPAS) https://nbpas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification
Malpractice History	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification –Sanctions and other sources

Sanction Information	Source of Verification	Method of Verification
State & Federal Sanctions and Other Sources	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=true	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Primary Source Verification Table

	Medi-Cal Suspended & Ineligible List https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Drug Code Limitation Listing of practitioners and/or medical groups placed on P/DCL sanction, https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Department of Health Care Service (DHCS)- Restricted Provider Database	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS.gov Centers for Medicare & Medicaid Services – Medicare Opt-Out Physicians https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html For a listing of all physicians and practitioners that are currently opted out of Medicare: https://data.cms.gov/tools/provider-opt-out-affidavits-look-up-tool	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Other Sanction Sources	AMA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are

		electronically tracked and dated.

Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 | CORRECT MARK: X | INCORRECT MARKS: ✓ •

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 Personal Information and Professional IDs

Provider Type

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

YES NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* SUFFIX (JR, III)

FIRST NAME* MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME SUFFIX (JR, III)

OTHER FIRST NAME OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (MM DD YYYY) DATE STOPPED USING OTHER NAME (MM DD YYYY)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE DATE OF BIRTH* (MM DD YYYY)

CITY OF BIRTH STATE OF BIRTH COUNTRY OF BIRTH

SSN* FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE

Home Address

NUMBER STREET APT NUMBER

CITY STATE ZIP CODE

TELEPHONE

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

Non-licensed professionals should enter certification/ registration number in the space provided for license number.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER?* YES NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* YES NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

0 — — —

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (M M D D Y Y Y Y)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 — Education and Training

Undergraduate School(s)

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

START DATE (M M Y Y Y Y) | END DATE (GRADUATION DATE) (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

GRADUATE TYPE*:

☐ U.S. OR CANADIAN GRADUATE ☐ NON-U.S./CANADIAN GRADUATE ☐ FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./ CANADIAN ONLY) | NAME OF U.S./ CANADIAN SCHOOL:

START DATE* (M M Y Y Y Y) | END DATE (GRADUATION DATE)* (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY | COUNTRY CODE | POSTAL CODE

START DATE* (M M Y Y Y Y) | END DATE (GRADUATION DATE)* (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? ☐ YES ☐ NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

☐ INTERNSHIP/ RESIDENCY ☐ FELLOWSHIP ☐ OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3080

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Secondary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information (Continued)

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

			EXPIRATION DATE													
BASIC LIFE SUPPORT?*	YES	NO	M	M	D	D	Y	Y	Y	Y	ADV LIFE SUPPORT IN OB?*	YES	NO	M	M	D	D	Y	Y	Y	Y
CPR?*	YES	NO	M	M	D	D	Y	Y	Y	Y	ADV TRAUMA LIFE SUPPORT?*	YES	NO	M	M	D	D	Y	Y	Y	Y
ADV CARDIAC LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y	PEDIATRIC ADVANCED LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y
NEONATAL ADVANCED LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y											

Practice Interests

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION. ☐

LAST NAME

FIRST NAME M.I.

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP CODE

TELEPHONE FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the e-mail address, if available.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION ☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

TELEPHONE* FAX

E-MAIL ADDRESS

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* ☐ YES ☐ NO

IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* ☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?* ☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* ☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO

IF YES

GENDER LIMITATIONS ☐ MALE ONLY ☐ NONE ☐ FEMALE ONLY

AGE LIMITATIONS ☐☐ MINIMUM AGE ☐☐ MAXIMUM AGE

LIST OTHER LIMITATIONS

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information (Continued)

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Languages

Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
DRAWING BLOOD? YES NO	AGE APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES NO
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Partners/ Associates

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Section 5 — Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* YES NO

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

3087

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 — Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (M M Y Y Y Y) | AFFILIATION END DATE (M M Y Y Y Y) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (M M Y Y Y Y) | AFFILIATION END DATE (M M Y Y Y Y) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 — Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION. ☐

CARRIER OR SELF-INSURED NAME* | SELF-INSURED?* ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 31.

CARRIER OR SELF-INSURED NAME | SELF-INSURED? ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Section 7 — Work History and References

Military Duty

Are you currently on active military duty or military reserve?* ☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

Section 7 — Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER — STREET — SUITE/BUILDING

CITY — STATE — ZIP/POSTAL CODE

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER — STREET — SUITE/BUILDING

CITY — STATE — ZIP/POSTAL CODE

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 — Work History and References (Continued)

Gaps in Professional / Work History

If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALED.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

Reference 1

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 2

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 3

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

1. ☐ YES ☐ NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
2. ☐ YES ☐ NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
7. ☐ YES ☐ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?*
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ☐ YES ☐ NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ☐ YES ☐ NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
16. ☐ YES ☐ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. ☐ YES ☐ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ☐ YES ☐ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. ☐ YES ☐ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?*
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other Relevant Education
Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 | **Education and Training**

Fifth Pathway Education

FIFTH PATHWAY GRADUATES ONLY

INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY)

Other Relevant Education

If you need to report additional Education, photocopy this page as needed and submit as instructed.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

Other Training
Supplemental Form

⁎ REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 Education and Training

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3096

Additional Specialty Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

3097

Partners/Associates Supplemental Form

Section 4 — Practice Location Information

Partner/ Associates

Use this page to report additional partners/associates at the designated practice location.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Check "Covering Colleague?" if he/she provides coverage for you at THIS location.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ☐☐ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

3098

Covering Colleagues
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information**

Covering Colleagues

Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Covering Colleagues, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME SPECIALTY CODE
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

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LAST NAME SPECIALTY CODE
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

LAST NAME SPECIALTY CODE
FIRST NAME M.I. PROVIDER TYPE (CODE PG 36)

3099

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

LOCATION* #

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPON-DENCE HERE?* YES NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* USE INDIVIDUAL TAX ID USE GROU TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

3100

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

24/7 PHONE COVERAGE?* YES NO

IF YES ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO

IF YES

GENDER LIMITATIONS: MALE ONLY NONE FEMALE ONLY

AGE LIMITATIONS: MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

3101

Practice Location Information
Supplemental Form

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* YES NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

3102

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

→ **LOCATION* #**

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
DRAWING BLOOD? YES NO	AGE APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES NO
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* #

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	FIRST NAME	M.I.	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	FIRST NAME	M.I.	SPECIALTY CODE	PROVIDER TYPE (CODE PG 36)

Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (MMYYYY) | AFFILIATION END DATE (MMYYYY)

FULL, UNRESTRICTED PRIVILEGES? YES NO

ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Professional Liability Insurance Carrier
Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 | **Professional Liability Insurance Carrier**

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

CARRIER OR SELF-INSURED NAME | SELF-INSURED? YES NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

CARRIER OR SELF-INSURED NAME | SELF-INSURED? YES NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Work History
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 | **Work History**

Work History

Use this form to continue listing work history.

If you need additional space for Work History, photocopy this page as needed and submit as instructed.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Training / Work History Gaps
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 | **Professional Training / Work History Gaps**

Professional Training / Work History Gaps

Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three month in duration or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

Disclosure Questions
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 | **Disclosure Questions**

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

Malpractice Claims Explanation
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 | **Malpractice Claims Explanation**

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF OCCURRENCE* M M D D Y Y Y Y

DATE CLAIM WAS FILED* M M D D Y Y Y Y

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)

☐ OPEN ☐ CLOSED

IF SETTLED, ENTER DATE CLAIM WAS SETTLED M M D D Y Y Y Y

PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE POLICY NUMBER

$, , AMOUNT OF AWARD OR SETTLEMENT*

METHOD OF RESOLUTION?* ☐ DISMISSED ☐ SETTLED ☐ MEDIATION ☐ ARBITRATION ☐ JUDGMENT FOR DEFENDANT(S) ☐ JUDGMENT FOR PLAINTIFF(S)

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* ☐ PRIMARY DEFENDANT ☐ CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY)

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)

DID THE ALLEGED INJURY RESULT IN DEATH? ☐ YES ☐ NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* ☐ YES ☐ NO

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Code Lists

Provider Type Codes

001 Medical Doctor (MD)
002 Doctor of Dental Surgery (DDS)
003 Doctor of Dental Medicine (DMD)
004 Doctor of Podiatric Medicine (DPM)
005 Doctor of Chiropractic (DC)
007 Osteopathic Doctor (DO)

020 Acupuncturist
021 Alcohol/Drug Counselor
022 Audiologist
023 Biofeedback Technician
024 Certified Registered Nurse Anesthetist
025 Christian Science Practitioner
026 Clinical Nurse Specialist
027 Clinical Psychologist
028 Clinical Social Worker
029 Dietician
030 Licensed Practical Nurse
031 Marriage/Family Therapist
032 Massage Therapist
033 Naturopath
034 Neuropsychologist
035 Midwife
036 Nurse Midwife
037 Nurse Practitioner
038 Nutritionist
039 Occupational Therapist
040 Optician
041 Optometrist
042 Pharmacist
043 Physical Therapist
044 Physician Assistant
045 Professional Counselor
046 Registered Nurse
047 Registered Nurse First Assistant
048 Respiratory Therapist
049 Speech Pathologist

License Status Codes

001 Active
002 Canceled
003 Denied
004 Expired
005 Inactive
006 Lapsed
007 Limited
008 Pending
009 Probation
010 Provisional
011 Restricted
012 Revoked
013 Suspended
014 Surrendered
015 Temporary
016 Terminated
017 Time Limited
018 Unrestricted
019 Other

Country Codes

004 Afghanistan
008 Albania
012 Algeria
016 American Samoa
020 Andorra
024 Angola
660 Anguilla
010 Antarctica
028 Antigua and Barbuda
032 Argentina
051 Armenia
533 Aruba
036 Australia
040 Austria
031 Azerbaijan
044 Bahamas
048 Bahrain
050 Bangladesh
052 Barbados
112 Belarus
056 Belgium
084 Belize
204 Benin
060 Bermuda
064 Bhutan
068 Bolivia
070 Bosnia and Herzegovina
072 Botswana
074 Bouvet Island
076 Brazil
086 British Indian Ocean Territory
096 Brunei Darussalam
100 Bulgaria
854 Burkina Faso
108 Burundi
116 Cambodia
120 Cameroon
124 Canada
132 Cape Verde
136 Cayman Islands
140 Central African Republic
148 Chad
152 Chile
156 China
162 Christmas Island
166 Cocos (Keeling) Islands
170 Colombia
174 Comoros
178 Congo
180 Congo, Democratic Republic of the
184 Cook Islands
188 Costa Rica
384 Cote d'Ivoire
191 Croatia
192 Cuba
196 Cyprus
203 Czech Republic
208 Denmark
262 Djibouti
212 Dominica
214 Dominican Republic
626 East Timor (provisional)
218 Ecuador
818 Egypt
222 El Salvador
226 Equatorial Guinea
232 Eritrea
233 Estonia
231 Ethiopia
238 Falkland Islands (Malvinas)
234 Faroe Islands
242 Fiji
246 Finland
250 France
249 France, Metropolitan
254 French Guiana
258 French Polynesia
260 French Southern Territories
266 Gabon
270 Gambia
268 Georgia
276 Germany
288 Ghana
292 Gibraltar
300 Greece
304 Greenland
308 Grenada
312 Guadaloupe
316 Guam
320 Guatemala
324 Guinea
624 Guinea-Bissau
328 Guyana
332 Haiti
334 Heard Island and McDonald Islands
340 Honduras
344 Hong Kong
348 Hungary
352 Iceland
356 India
360 Indonesia
364 Iran
368 Iraq
372 Ireland
376 Israel
380 Italy
388 Jamaica
392 Japan
400 Jordan
398 Kazakhstan
404 Kenya
296 Kiribati
408 Korea, North
410 Korea, South
414 Kuwait
417 Kyrgyzstan
418 Laos
428 Latvia
422 Lebanon
426 Lesotho
430 Liberia
434 Libya
438 Liechtenstein
440 Lithuania
442 Luxembourg
446 Macau
807 Macedonia
450 Madagascar
454 Malawi
458 Malaysia
462 Maldives
466 Mali
470 Malta
584 Marshall Islands
474 Martinique
478 Mauritania
480 Mauritius
175 Mayotte
484 Mexico
583 Micronesia
498 Moldova
492 Monaco
496 Mongolia
500 Montserrat
504 Morocco
508 Mozambique
104 Myanmar
516 Namibia
520 Nauru
524 Nepal
528 Netherlands
530 Netherlands Antilles
540 New Caledonia
554 New Zealand
558 Nicaragua
562 Niger
566 Nigeria
570 Niue
574 Norfolk Island
580 Northern Mariana Islands
578 Norway
512 Oman
586 Pakistan
585 Palau
591 Panama
598 Papua New Guinea
600 Paraguay
604 Peru
608 Philippines
612 Pitcairn
616 Poland
620 Portugal
630 Puerto Rico
634 Qatar
638 Réunion
642 Romania
643 Russian Federation
646 Rwanda
654 Saint Helena
659 Saint Kitts and Nevis
662 Saint Lucia
666 Saint Pierre and Miquelon
670 Saint Vincent and the Grenadines

Code Lists

Country Codes (continued)

882	Samoa
674	San Marino
678	São Tomé and Príncipe
682	Saudi Arabia
683	Scotland
686	Senegal
690	Seychelles
694	Sierra Leone
702	Singapore
703	Slovakia
705	Slovenia
090	Solomon Islands
706	Somalia
710	South Africa
239	South Georgia and the South Sandwich Islands
724	Spain
144	Sri Lanka
736	Sudan
740	Suriname
744	Svalbard and Jan Mayen
748	Swaziland
752	Sweden
756	Switzerland
760	Syria
158	Taiwan
762	Tajikistan
834	Tanzania
764	Thailand
768	Togo
772	Tokelau
776	Tonga
780	Trinidad and Tobago
788	Tunisia
792	Turkey795 Turkmenistan
796	Turks and Caicos Islands
798	Tuvalu
800	Uganda
804	Ukraine
784	United Arab Emirates
826	United Kingdom
840	United States
581	U.S. Minor Outlying Islands
858	Uruguay
860	Uzbekistan
548	Vanuatu
336	Vatican City State (Holy See)
862	Venezuela
704	Viet Nam
092	Virgin Islands, British
850	Virgin Islands, U.S.
876	Wallis and Fortuna Islands
732	Western Sahara (provisional)
887	Yemen
891	Yugoslavia
894	Zambia
716	Zimbabwe

Language Codes

001	Abkhazian
002	Afan (Oromo)
003	Afar
004	Afrikaans
005	Albanian
006	Amharic
007	Arabic
008	Armenian
009	Assamese
010	Zerbaijani
011	Bashkir
012	Basque
013	Bengali;Bangla
014	Bhutani
015	Bihari
016	Bislama
017	Breton
018	Bulgarian
019	Burmese
020	Byelorussian
021	Cambodian
022	Catalan
023	Chinese
024	Corsican
025	Croatian
026	Czech
027	Danish
028	Dutch
140	English
030	Esperonto
031	Estonian
032	Faroese
033	Fiji
034	Finnish
035	French
036	Frisian
037	Galican
038	Georgian
039	German
040	Greek
041	Greenlandic
042	Guarani
043	Gujarati
044	Hausa
045	Hebrew
046	Hindi
047	Hungarian
048	Icelandic
049	Indonesian
050	Interlingua
051	Interlingue
052	Inuktitut
053	Inupiak
054	Irish
055	Italian
056	Japanese
057	Javanese
058	Kannada
059	Kashmiri
060	Kazakh
061	Kinyarwanda
062	Kirghiz
063	Kurundi
064	Korean
065	Kurdish
066	Laothian
067	Latin
068	Latvian;Lettish
069	Lingala
070	Lithuanian
071	Macedonian
072	Malagasy
073	Malay
074	Malayalam
075	Maltese
076	Maori
077	Marathi
078	Moldavian
079	Mongolian
080	Nauru
081	Nepali
082	Norwegian
083	Occitan
084	Oriya
085	Pashto;Pushto
086	Persian (Farsi)
087	Polish
088	Portuguese
089	Punjabi
090	Quechua
091	Rhaeto-Romance
092	Romanian
093	Russian
094	Samoan
095	Sangho
096	Sanskrit
097	Scot Gaelic
098	Serbian
099	Serbo-Croatian
100	Sesotho
101	Setswana
102	Shona
103	Sindhi
104	Singhalese
105	Siswati
106	Slovak
107	Slovenian
108	Somali
109	Spanish
110	Sundanese
111	Swahili
112	Swedish
113	Tagalog
114	Tajik
115	Tamil
116	Tatar
117	Telugu
118	Thai
119	Tibetan
120	Tigrinya
121	Tonga
122	Tsonga
123	Turkish
124	Turkmen
125	Twi
126	Uigur
127	Ukrainian
128	Urdu
129	Uzbek
130	Vietnamese
131	Volapuk
132	Welsh
133	Wolof
134	Xhosa
135	Yiddish
136	Yoruba
10	Zerbaijani
137	Zhuang
138	Zulu

Code Lists

U.S. / Canadian Professional School Codes

Alabama
300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas
003 University of Arkansas College of Medicine

Arizona
500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California
801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angele
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado
306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut
405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia
016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida
800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia
022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii
026 John A. Burns School of Medicine

Iowa
802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois
028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana
316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas
036 University of Kansas School of Medicine

Kentucky
506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana
319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts
042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland
046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine
507 University of New England, College of Osteopathic Medicine

Michigan
049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota
052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri
410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine

056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Mississippi
328 University of Mississippi School of Dentistry
059 University of Mississippi School of Medicine

North Carolina
060 Duke University School of Medicine
061 The Brody School of Medicine at East Carolina University
329 University of North Carolina at Chapel Hill School of Dentistry
062 University of North Carolina at Chapel Hill School of Medicine
063 Wake Forest University School of Medicine

North Dakota
064 University of North Dakota School of Medicine and Health Sciences

Nebraska
330 Creighton University School of Dentistry
065 Creighton University School of Medicine
066 University of Nebraska College of Medicine
331 University of Nebraska Medical Center, College of Dentistry

New Hampshire
067 Dartmouth Medical School

New Jersey
068 Robert Wood Johnson Medical School
069 University of Medicine and Dentistry of New Jersey (UMDNJ)
332 UMDNJ, New Jersey Dental School
511 UMDNJ, School of Osteopathic Medicine

New Mexico
070 University of New Mexico School of Medicine

Nevada
071 University of Nevada School of Medicine

New York
072 Albany Medical College
073 Albert Einstein College of Medicine
074 Columbia University College of Physicians and Surgeons
333 Columbia University School of Dental and Oral Surgery
075 Joan & Sanford I. Weill Medical College of Cornell University
076 Mount Sinai School of Medicine of New York University
412 New York Chiropractic College
512 NY College of Osteopathic Medicine of the NY Institute of Technology
077 New York Medical College
334 New York University Kriser Dental Center
078 New York University School of Medicine
335 State University of New York at Buffalo School of Dental Medicine
082 State University of New York at Buffalo School of Medicine
336 State University of New York at Stony Brook School of Dental Medicine
081 State University of New York at Stony Brook School of Medicine
079 State University of New York College of Medicine
080 State University of New York Upstate Medical University
083 University of Rochester School of Medicine and Dentistry

Ohio
337 Case Western Reserve University School of Dentistry
084 Case Western Reserve University School of Medicine
085 Medical College of Ohio
086 Northeastern Ohio Universities College of Medicine
803 Ohio College of Podiatric Medicine
338 Ohio State University College of Dentistry
087 Ohio State University College of Medicine and Public Health
513 Ohio University College of Osteopathic Medicine
088 University of Cincinnati College of Medicine
089 Wright State University School of Medicine

Oklahoma
514 Oklahoma State University, College of Osteopathic Medicine
339 University of Oklahoma College of Dentistry
090 University of Oklahoma College of Medicine

Oregon
091 Oregon Health & Science University School of Medicine
340 Oregon Health Sciences University School of Dentistry
413 Western States Chiropractic College

Pennsylvania
092 Jefferson Medical College of Thomas Jefferson University
515 Lake Erie College of Osteopathic Medicine
093 MCP Hahnemann University School of Medicine
094 Pennsylvania State University College of Medicine
516 Philadelphia College of Osteopathic Medicine
341 Temple University School of Dentistry
095 Temple University School of Medicine
805 Temple University School of Podiatric Medicine
342 University of Pennsylvania School of Dental Medicine
096 University of Pennsylvania School of Medicine
343 University of Pittsburgh School of Dental Medicine
097 University of Pittsburgh School of Medicine

Puerto Rico
098 Ponce School of Medicine
099 Universidad Central del Caribe School of Medicine
100 University of Puerto Rico School of Medicine
344 University of Puerto Rico School of Dentistry

Rhode Island
101 Brown Medical School

South Carolina
345 Medical University of South Carolina College of Dental Medicine
102 Medical University of South Carolina College of Medicine
414 Sherman College of Chiropractic
103 University of South Carolina School of Medicine

South Dakota
104 University of South Dakota School of Medicine

Tennessee
105 East Tennessee State University
346 Meharry Medical College School of Dentistry
106 Meharry Medical College School of Medicine
347 University of Tennessee College of Dentistry
107 University of Tennessee College of Medicine
108 Vanderbilt University School of Medicine

Texas
348 Baylor College of Dentistry
109 Baylor College of Medicine
415 Parker College of Chiropractic
416 Texas Chiropractic College
110 Texas Tech University Health Sciences Center School of Medicine
111 The Texas A & M University System College of Medicine
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School
112 University of Texas Medical Branch at Galveston
113 University of Texas Medical School at Houston
114 University of Texas Medical School at San Antonio
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah
116 University of Utah School of Medicine

Virginia
117 Eastern VA Medical School of the Medical College of Hampton Roads
118 University of Virginia School of Medicine Health System
351 Virginia Commonwealth University School of Dentistry
119 Virginia Commonwealth University School of Medicine

Vermont
120 University of Vermont College of Medicine

Washington
352 University of Washington School of Dentistry
121 University of Washington School of Medicine

Wisconsin
353 Marquette University School of Dentistry
122 Medical College of Wisconsin
123 University of Wisconsin Medical School

West Virginia
124 Joan C. Edwards School of Medicine at Marshall University
518 West Virginia School of Osteopathic Medicine
354 West Virginia University School of Dentistry
125 West Virginia University School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Canada

355 Dalhousie University Faculty of Dentistry
126 Dalhousie University Faculty of Medicine
357 Laval University Faculty of Dentistry
127 Laval University Faculty of Medicine
356 McGill University Faculty of Dentistry
128 McGill University Faculty of Medicine
129 McMaster University School of Medicine
130 Memorial University of Newfoundland Faculty of Medicine
131 Queen's University Faculty of Health Sciences
132 The University of Western Ontario Faculty of Medicine & Dentistry
133 Universite de Montreal Faculty of Medicine
134 Universite de Sherbrooke Faculty of Medicine
358 University of Alberta Faculty of Dentistry
135 University of Alberta Faculty of Medicine
359 University of British Columbia Faculty of Dentistry
136 University of British Columbia Faculty of Medicine
137 University of Calgary Faculty of Medicine
360 University of Manitoba Faculty of Dentistry
138 University of Manitoba Faculty of Medicine
361 University of Montreal Faculty of Dentistry
139 University of Ottawa Faculty of Medicine
362 University of Saskatchewan College of Dentistry
140 University of Saskatchewan College of Medicine
363 University of Toronto Faculty of Dentistry
141 University of Toronto Faculty of Medicine
364 University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247 Allergy & Immunology
246 Allergy & Immunology, Allergy
291 Allergy & Immunology, Clinical & Laboratory Immunology
249 Anesthesiology
235 Anesthesiology, Addiction Medicine
258 Anesthesiology, Critical Care Medicine
126 Anesthesiology, Pain Medicine
363 Clinical Pharmacology
367 Colon & Rectal Surgery
263 Dermatology
292 Dermatology, Clinical & Laboratory Dermatological Immunology
444 Dermatology, Dermatological Surgery
266 Dermatology, Dermatopathology
264 Dermatology, MOHS-Micrographic Surgery
443 Dermatology, Pediatric Dermatology
268 Emergency Medicine
445 Emergency Medicine, Emergency Medical Services
427 Emergency Medicine, Medical Toxicology
348 Emergency Medicine, Pediatric Emergency Medicine
395 Emergency Medicine, Sports Medicine
446 Emergency Medicine, Undersea and Hyperbaric Medicine
391 Facial Plastic Surgery
272 Family Practice
447 Family Practice, Addiction Medicine
237 Family Practice, Adolescent Medicine
448 Family Practice, Adult Medicine
282 Family Practice, Geriatric Medicine
396 Family Practice, Sports Medicine
225 General Practice
479 Hospitalist
301 Internal Medicine
449 Internal Medicine, Addiction Medicine
236 Internal Medicine, Adolescent Medicine
248 Internal Medicine, Allergy & Immunology
255 Internal Medicine, Cardiovascular Disease
294 Internal Medicine, Clinical & Laboratory Immunology
253 Internal Medicine, Clinical Cardiac Electrophysiology
257 Internal Medicine, Critical Care Medicine
267 Internal Medicine, Endocrinology, Diabetes & Metabolism
275 Internal Medicine, Gastroenterology
285 Internal Medicine, Geriatric Medicine
287 Internal Medicine, Hematology
288 Internal Medicine, Hematology & Oncology
450 Internal Medicine, Hepatology
299 Internal Medicine, Infectious Disease
451 Internal Medicine, Interventional Cardiology
453 Internal Medicine, Magnetic Resonance Imaging (MRI)
325 Internal Medicine, Medical Oncology
309 Internal Medicine, Nephrology
378 Internal Medicine, Pulmonary Disease
390 Internal Medicine, Rheumatology
397 Internal Medicine, Sports Medicine
433 Laboratories, Clinical Medical Laboratory
481 Legal Medicine
278 Medical Genetics, Clinical Biochemical Genetics
261 Medical Genetics, Clinical Cytogenetic
277 Medical Genetics, Clinical Genetics (M.D.)
280 Medical Genetics, Clinical Molecular Genetics
455 Medical Genetics, Molecular Genetic Pathology
454 Medical Genetics, Ph.D. Medical Genetics
306 Neonatal-Perinatal Medicine
308 Neopathology
409 Neurological Surgery
330 Neuromusculoskeletal Medicine & OMM
440 Neuromusculoskeletal Medicine, Sports Medicine
317 Nuclear Medicine
318 Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine
315 Nuclear Medicine, Nuclear Cardiology
316 Nuclear Medicine, Nuclear Imaging & Therapy
321 Obstetrics & Gynecology
260 Obstetrics & Gynecology, Critical Care Medicine
326 Obstetrics & Gynecology, Gynecologic Oncology
286 Obstetrics & Gynecology, Gynecology
303 Obstetrics & Gynecology, Maternal & Fetal Medicine
320 Obstetrics & Gynecology, Obstetrics
271 Obstetrics & Gynecology, Reproductive Endocrinology
328 Ophthalmology
441 Oral & Maxillofacial Surgery
411 Orthopaedic Surgery
412 Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
456 Orthopaedic Surgery, Foot and Ankle Orthopaedics
406 Orthopaedic Surgery, Hand Surgery
415 Orthopaedic Surgery, Orthopaedic Surgery of the Spine
416 Orthopaedic Surgery, Orthopaedic Trauma
457 Orthopaedic Surgery, Sports Medicine
119 Orthopedic
331 Otolaryngology
458 Otolaryngology, Otolaryngic Allergy
459 Otolaryngology, Otolaryngology/ Facial Plastic Surgery
332 Otolaryngology, Otology & Neurotology
357 Otolaryngology, Pediatric Otolaryngology
417 Otolaryngology, Plastic Surgery within the Head & Neck
480 Pain Medicine, Interventional Pain Medicine
337 Pain Medicine
338 Pathology, Anatomic Pathology
340 Pathology, Anatomic Pathology & Clinical Pathology
250 Pathology, Blood Banking & Transfusion Medicine
344 Pathology, Chemical Pathology
302 Pathology, Clinical Pathology/Laboratory Medicine
262 Pathology, Cytopathology
265 Pathology, Dermatopathology
273 Pathology, Forensic Pathology
290 Pathology, Hematology
298 Pathology, Immunopathology
305 Pathology, Medical Microbiology
461 Pathology, Molecular Genetic Pathology
312 Pathology, Neuropathology
358 Pathology, Pediatric Pathology
244 Pediatrics
239 Pediatrics, Adolescent Medicine
295 Pediatrics, Clinical & Laboratory Immunology
462 Pediatrics, Developmental – Behavioral Pediatrics
354 Pediatrics, Medical Toxicology
356 Pediatrics, Neurodevelopmental Disabilities
345 Pediatrics, Pediatric Allergy & Immunology
346 Pediatrics, Pediatric Cardiology
347 Pediatrics, Pediatric Critical Care Medicine
463 Pediatrics, Pediatric Emergency Medicine
349 Pediatrics, Pediatric Endocrinology

Code Lists

Specialty Codes - MD/DO Only

350	Pediatrics, Pediatric Gastroenterology
351	Pediatrics, Pediatric Hematology-Oncology
352	Pediatrics, Pediatric Infectious Diseases
355	Pediatrics, Pediatric Nephrology
359	Pediatrics, Pediatric Pulmonology
361	Pediatrics, Pediatric Rheumatology
398	Pediatrics, Sports Medicine
365	Physical Medicine & Rehabilitation
468	Physical Medicine & Rehabilitation, Pain Medicine
389	Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine
466	Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine
469	Physical Medicine & Rehabilitation, Sports Medicine
419	Plastic Surgery
470	Plastic Surgery, Plastic Surgery Within the Head and Neck
407	Plastic Surgery, Surgery of the Hand
242	Preventive Medicine, Aerospace Medicine
429	Preventive Medicine, Medical Toxicology
112	Preventive Medicine, Occupational Medicine
471	Preventive Medicine, Sports Medicine
431	Preventive Medicine, Undersea and Hyperbaric Medicine
114	Preventive Medicine/Occupational Environmental Medicine
370	Psychiatry & Neurology, Addiction Medicine
473	Psychiatry & Neurology, Addiction Psychiatry
371	Psychiatry & Neurology, Child & Adolescent Psychiatry
313	Psychiatry & Neurology, Clinical Neurophysiology
274	Psychiatry & Neurology, Forensic Psychiatry
373	Psychiatry & Neurology, Geriatric Psychiatry
472	Psychiatry & Neurology, Neurodevelopmental Disabilities
100	Psychiatry & Neurology, Neurology
311	Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology
474	Psychiatry & Neurology, Pain Medicine
368	Psychiatry & Neurology, Psychiatry
475	Psychiatry & Neurology, Sports Medicine
476	Psychiatry & Neurology, Vascular Neurology
366	Public Health & General Preventive Medicine
252	Radiology, Body Imaging
173	Radiology, Diagnostic Radiology
430	Radiology, Diagnostic Ultrasound
314	Radiology, Neuroradiology
319	Radiology, Nuclear Radiology
360	Radiology, Pediatric Radiology
380	Radiology, Radiation Oncology
477	Radiology, Radiological Physics
381	Radiology, Therapeutic Radiology
384	Radiology, Vascular & Interventional Radiology
434	Supplier
399	Surgery
418	Surgery, Pediatric Surgery
420	Surgery, Plastic and Reconstructive Surgery
405	Surgery, Surgery of the Hand
425	Surgery, Surgical Critical Care
413	Surgery, Surgical Oncology
423	Surgery, Trauma Surgery
400	Surgery, Vascular Surgery
421	Thoracic Surgery (Cardiothoracic Vascular Surgery)
442	Transplant Surgery
424	Urology

Specialty Codes - DDS / DMD / DPM / DC

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD

2	Dentist
13	Dentist, Dental Public Health
14	Dentist, Endodontics
438	Dentist, General Practice
16	Dentist, Oral and Maxillofacial Pathology
439	Dentist, Oral and Maxillofacial Radiology
20	Dentist, Oral and Maxillofacial Surgery
15	Dentist, Orthodontics and Dentofacial Orthopedics
17	Dentist, Pediatric Dentistry
18	Dentist, Periodontics
19	Dentist, Prosthodontics

DPM

3	Podiatrist
231	Podiatrist, Foot & Ankle Surgery
230	Podiatrist, Foot Surgery
225	Podiatrist, General Practice
227	Podiatrist, Primary Podiatric Medicine
226	Podiatrist, Public Medicine
228	Podiatrist, Radiology
229	Podiatrist, Sports Medicine

DC

1	Chiropractor
5	Chiropractor, Internist
6	Chiropractor, Neurology
7	Chiropractor, Nutrition
8	Chiropractor, Occupational Medicine
9	Chiropractor, Orthopedic
10	Chiropractor, Radiology
11	Chiropractor, Sports Physician
12	Chiropractor, Thermography

Specialty Codes - Allied Providers

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501	Acupuncturist
503	Audiologist
504	Audiologist, Assistive Technology Practitioner
505	Audiologist, Assistive Technology Supplier
531	Christian Science Practitioner
727	Clinical Nurse Specialist
728	Clinical Nurse Specialist, Acute Care
729	Clinical Nurse Specialist, Adult Health
730	Clinical Nurse Specialist, Chronic Care
731	Clinical Nurse Specialist, Community Health/Public Health
732	Clinical Nurse Specialist, Critical Care Medicine
733	Clinical Nurse Specialist, Emergency
734	Clinical Nurse Specialist, Ethics
735	Clinical Nurse Specialist, Family Health
736	Clinical Nurse Specialist, Gerontology
737	Clinical Nurse Specialist, Holistic
738	Clinical Nurse Specialist, Home Health
739	Clinical Nurse Specialist, Informatics
740	Clinical Nurse Specialist, Long-Term Care
741	Clinical Nurse Specialist, Medical-Surgical
742	Clinical Nurse Specialist, Neonatal
743	Clinical Nurse Specialist, Neuroscience
744	Clinical Nurse Specialist, Occupational Health
745	Clinical Nurse Specialist, Oncology
746	Clinical Nurse Specialist, Oncology, Pediatrics
747	Clinical Nurse Specialist, Pediatrics
748	Clinical Nurse Specialist, Perinatal
749	Clinical Nurse Specialist, Perioperative
750	Clinical Nurse Specialist, Psychiatric/Mental Health
751	Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
752	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
753	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
754	Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
755	Clinical Nurse Specialist, Psychiatric/Mental Health, Community
756	Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
757	Clinical Nurse Specialist, Rehabilitation
759	Clinical Nurse Specialist, School
758	Clinical Nurse Specialist, Transplantation
760	Clinical Nurse Specialist, Women's Health
513	Counselor
514	Counselor, Addiction (Substance Use Disorder)
515	Counselor, Mental Health
516	Counselor, Professional
533	Dietitian, Registered
536	Dietitian, Registered, Nutrition, Metabolic
534	Dietitian, Registered, Nutrition, Pediatric
535	Dietitian, Registered, Nutrition, Renal
651	Licensed Practical Nurse
517	Marriage & Family Therapist
547	Massage Therapist
549	Midwife, Certified
652	Midwife, Certified Nurse
551	Naturopath
553	Neuropsychologist
653	Nurse Anesthetist, Certified Registered
654	Nurse Practitioner
655	Nurse Practitioner, Acute Care
656	Nurse Practitioner, Adult Health
658	Nurse Practitioner, Community Health
657	Nurse Practitioner, Critical Care Medicine
659	Nurse Practitioner, Family

Code Lists

Specialty Codes - Allied Providers (continued)

660 Nurse Practitioner, Gerontology
661 Nurse Practitioner, Neonatal
662 Nurse Practitioner, Neonatal, Critical Care
670 Nurse Practitioner, Obstetrics & Gynecology
671 Nurse Practitioner, Occupational Health
663 Nurse Practitioner, Pediatrics
664 Nurse Practitioner, Pediatrics, Critical Care
666 Nurse Practitioner, Perinatal
667 Nurse Practitioner, Primary Care
665 Nurse Practitioner, Psych/Mental Health
668 Nurse Practitioner, School
669 Nurse Practitioner, Women's Health
537 Nutritionist
538 Nutritionist, Nutrition, Education
555 Occupational Therapist
556 Occupational Therapist, Ergonomics
557 Occupational Therapist, Hand
558 Occupational Therapist, Human Factors
559 Occupational Therapist, Neurorehabilitation
560 Occupational Therapist, Pediatrics
561 Occupational Therapist, Rehabilitation, Driver
563 Optician
565 Optometrist
566 Optometrist, Corneal and Contact Management
567 Optometrist, Low Vision Rehabilitation
571 Optometrist, Occupational Vision
568 Optometrist, Pediatrics
569 Optometrist, Sports Vision
570 Optometrist, Vision Therapy
573 Pharmacist
574 Pharmacist, General Practice
575 Pharmacist, Nuclear Pharmacy
576 Pharmacist, Nutrition Support
577 Pharmacist, Pharmacotherapy
578 Pharmacist, Psychopharmacy
580 Physical Therapist
581 Physical Therapist, Cardiopulmonary
583 Physical Therapist, Electrophysiology, Clinical
582 Physical Therapist, Ergonomics
584 Physical Therapist, Geriatrics
585 Physical Therapist, Hand
586 Physical Therapist, Human Factors
587 Physical Therapist, Neurology
590 Physical Therapist, Orthopedic
588 Physical Therapist, Pediatrics
589 Physical Therapist, Sports
592 Physician Assistant
593 Physician Assistant, Medical
594 Physician Assistant, Surgical
596 Psychologist
597 Psychologist, Addiction (Substance Use Disorder)
598 Psychologist, Adult Development & Aging
599 Psychologist, Behavioral
602 Psychologist, Child, Youth & Family
600 Psychologist, Clinical
601 Psychologist, Counseling
603 Psychologist, Educational
604 Psychologist, Exercise & Sports
605 Psychologist, Family
606 Psychologist, Forensic
607 Psychologist, Health
608 Psychologist, Men & Masculinity
609 Psychologist, Mental Retardation & Developmental Disabilities
610 Psychologist, Psychoanalysis
611 Psychologist, Psychotherapy
612 Psychologist, Psychotherapy, Group
613 Psychologist, Rehabilitation
614 Psychologist, School
615 Psychologist, Women
672 Registered Nurse
673 Registered Nurse, Addiction (Substance Use Disorder)
674 Registered Nurse, Administrator
711 Registered Nurse, Ambulatory Care
681 Registered Nurse, Cardiac Rehabilitation
676 Registered Nurse, Case Management
677 Registered Nurse, College Health
678 Registered Nurse, Community Health
680 Registered Nurse, Continence Care
679 Registered Nurse, Continuing Education/Staff Development
675 Registered Nurse, Critical Care Medicine
682 Registered Nurse, Diabetes Educator
683 Registered Nurse, Dialysis, Peritoneal
684 Registered Nurse, Emergency
685 Registered Nurse, Enterostomal Therapy
686 Registered Nurse, Flight
688 Registered Nurse, Gastroenterology
687 Registered Nurse, General Practice
689 Registered Nurse, Gerontology
691 Registered Nurse, Hemodialysis
690 Registered Nurse, Home Health
692 Registered Nurse, Hospice
694 Registered Nurse, Infection Control
693 Registered Nurse, Infusion Therapy
695 Registered Nurse, Lactation Consultant
696 Registered Nurse, Maternal Newborn
697 Registered Nurse, Medical-Surgical
699 Registered Nurse, Neonatal Intensive Care
700 Registered Nurse, Neonatal, Low-Risk
701 Registered Nurse, Nephrology
702 Registered Nurse, Neuroscience
698 Registered Nurse, Nurse Massage Therapist (NMT)
703 Registered Nurse, Nutrition Support
719 Registered Nurse, Obstetric, High-Risk
720 Registered Nurse, Obstetric, Inpatient
721 Registered Nurse, Occupational Health
722 Registered Nurse, Oncology
725 Registered Nurse, Ophthalmic
724 Registered Nurse, Orthopedic
726 Registered Nurse, Ostomy Care
723 Registered Nurse, Otorhinolaryngology & Head-Neck
704 Registered Nurse, Pain Management
706 Registered Nurse, Pediatric Oncology
705 Registered Nurse, Pediatrics
710 Registered Nurse, Perinatal
714 Registered Nurse, Plastic Surgery
708 Registered Nurse, Psych/Mental Health
709 Registered Nurse, Psych/Mental Health, Adult
707 Registered Nurse, Psych/Mental Health, Child & Adolescent
712 Registered Nurse, Rehabilitation
713 Registered Nurse, Reproductive Endocrinology/Infertility
715 Registered Nurse, School
716 Registered Nurse, Urology
718 Registered Nurse, Women's Health Care, Ambulatory
717 Registered Nurse, Wound Care
617 Respiratory Therapist, Certified
618 Respiratory Therapist, Certified, Critical Care
620 Respiratory Therapist, Certified, Educational
619 Respiratory Therapist, Certified, Emergency Care
622 Respiratory Therapist, Certified, General Care
621 Respiratory Therapist, Certified, Geriatric Care
623 Respiratory Therapist, Certified, Home Health
628 Respiratory Therapist, Certified, Neonatal/Pediatrics
627 Respiratory Therapist, Certified, Palliative/Hospice
629 Respiratory Therapist, Certified, Patient Transport
624 Respiratory Therapist, Certified, Pulmonary Diagnostics
626 Respiratory Therapist, Certified, Pulmonary Function Technologist
625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
630 Respiratory Therapist, Certified, SNF/Subacute Care
631 Respiratory Therapist, Registered
632 Respiratory Therapist, Registered, Critical Care
634 Respiratory Therapist, Registered, Educational
633 Respiratory Therapist, Registered, Emergency Care
636 Respiratory Therapist, Registered, General Care
635 Respiratory Therapist, Registered, Geriatric Care
637 Respiratory Therapist, Registered, Home Health
642 Respiratory Therapist, Registered, Neonatal/Pediatrics
641 Respiratory Therapist, Registered, Palliative/Hospice
643 Respiratory Therapist, Registered, Patient Transport
638 Respiratory Therapist, Registered, Pulmonary Diagnostics
640 Respiratory Therapist, Registered, Pulmonary Function Technologist
639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
644 Respiratory Therapist, Registered, SNF/Subacute Care
646 Social Worker, Clinical
648 Specialist/Technologist, Other, Biomedical Engineering
506 Speech-Language Pathologist
649 Technician, Other, Biomedical Engineering
502 Other, Not Listed

Code Lists

Specialty Boards - Allied Providers

940 Academy of Certified Social Workers
1150 ACNM Certification Council
360 American Academy of Ambulatory Care Nursing
1550 American Academy of Anesthesiologist Assistants
230 American Academy of Audiology
370 American Academy of Experts in Traumatic Stress
270 American Academy of Health Providers in the Addictive Disorders
200 American Academy of Medical Acupuncture
405 American Academy of Nurse Practitioners
380 American Academy of Nursing
1330 American Academy of Optometry
1480 American Academy of Physician Assistants
1110 American Association for Marriage and Family Therapy
390 American Association of Critical Care Nurses
1590 American Association of Nurse Anesthetists
330 American Association of Pastoral Counselors
1010 American Association of Sex Educators, Counselors and Therapists
710 American Board Medical Psychotherapists
280 American Board of Addiction Medicine
950 American Board of Examiners in Clinical Social Work
720 American Board of Medical Psyhotherapists & Psychodiagnosticians
400 American Board of Nursing Specialties
1240 American Board of Nutrition
1300 American Board of Occupational Medicine
1360 American Board of Ophthalmology
1510 American Board of Physical Therapy Specialties
700 American Board of Professional Psychology
1130 American Naturopath Certification Board
350 American Nurses Credentialing Center
740 American Psychological Association
750 American Psychological Society
760 American Psychotherapy Association
290 American Society of Addiction Medicine
1650 American Speech-Language-Hearing Association
250 Biofeedback Certification Institute of America
1430 Board of Pharmaceutical Specialties
1250 Commission on Dietetic Registration
960 Employee Assistance Professionals Association
780 National Association for the Advancement of Psychoanalysis
1450 National Association of Boards of Pharmacy
1600 National Association of Nurse Anesthetists
770 National Association of School Psychologists
980 National Association of Social Workers
1310 National Board for Certification in Occupational Therapy
1490 National Board for Certification of Orthopaedic Physician Assistants
790 National Board for Certified Clinical Hypnotherapists
310 National Board for Certified Counselors
1630 National Board for Respiratory Care
300 National Board of Addiction Examiners
800 National Board of Cognitive Behavioral Therapists
1350 National Board of Examiners in Optometry
1090 National Certification Board for Therapeutic Massage and Bodywork
210 National Certification Commission for Acupuncture and Oriental Medicine
1440 National Institute for Standards in Pharmacist Credentialing
220 Other - Not Listed

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards

044 American Board of Allergy & Immunology
045 American Board of Anesthesiology
046 American Board of Colon & Rectal Surgery
047 American Board of Dermatology
048 American Board of Emergency Medicine
049 American Board of Family Medicine
050 American Board of Internal Medicine
051 American Board of Medical Genetics
052 American Board of Neurological Surgery
053 American Board of Nuclear Medicine
054 American Board of Obstetrics & Gynecology
055 American Board of Ophthalmology
109 American Board of Oral & Maxillofacial Surgeons
056 American Board of Orthopedic Surgery
057 American Board of Otolaryngology
058 American Board of Pathology
059 American Board of Pediatrics
060 American Board of Physical Medicine & Rehabilitation
061 American Board of Plastic Surgery
062 American Board of Preventive Medicine
063 American Board of Psychiatry & Neurology
064 American Board of Radiology
065 American Board of Surgery
066 American Board of Thoracic Surgery
067 American Board of Urology
142 Boards other than ABMS/AOA

Dental Boards

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons
108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA

DO Boards

118 American Osteopathic Board of Anesthesiology
119 American Osteopathic Board of Dermatology
120 American Osteopathic Board of Emergency Medicine
121 American Osteopathic Board of Family Practice
123 American Osteopathic Board of Internal Medicine
124 American Osteopathic Board of Neurology and Psychiatry
125 American Osteopathic Board of Neuromuskuloskeletal Medicine
126 American Osteopathic Board of Nuclear Medicine
127 American Osteopathic Board of Obstetrics and Gynecology
128 American Osteopathic Board of Ophthalmology and Otolaryngology
129 American Osteopathic Board of Orthopedic Surgery
130 American Osteopathic Board of Pathology
131 American Osteopathic Board of Pediatrics
132 American Osteopathic Board of Preventive Medicine
133 American Osteopathic Board of Proctology
134 American Osteopathic Board of Radiology
135 American Osteopathic Board of Rehabilitation Medicine
136 American Osteopathic Board of Surgery

DPM Boards

140 American Board of Medical Specialists in Podiatry
137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138 American Board of Podiatric Surgery
139 American Council of Certified Podiatric Surgeons and Physicians

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ◯ Yes ◯ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ◯ Yes ◯ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ◯ Yes ◯ No

15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ◯ Yes ◯ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable) | **PRINTED NAME** | **DATE**

Continue to the Next Page for Information Release/ Acknowledgements

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:	505 City Parkway West				
City:	Orange	ST:	CA	Zip:	92868

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖

PRINTED NAME ✖

DATE ✖

Policy:	GG.1651Δ
Title:	**Assessment and Re-Assessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy ~~establishes~~describes the ~~framework to assess~~process by which CalOptima evaluates and determines an Organizational ~~Providers'~~Provider's (OPs) ~~participation~~ eligibility to participate in ~~the CalOptima provider network, prior to contracting and every three (3) years thereafter~~CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines ~~by which CalOptima shall evaluate and select~~ for evaluation of OPs ~~to participate~~participation eligibility in CalOptima~~,~~ programs, in accordance with ~~Title 42, Code of Federal Regulations, Section 422.204 and other~~ applicable laws, regulations, and regulatory guidance.

B. CalOptima may delegate the assessment and reassessment of OPs to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to assess and reassess OPs to participate in its CalOptima ~~network~~ programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO~~),~~) or his or her physician Designee~~,~~ shall have direct responsibility over and shall actively participate in the assessment and reassessment of an OP.

D. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima's findings for determining an OP's participation in CalOptima's provider network.

E. CalOptima shall require that the OP be successfully assessed, including confirmation that the OP is in good standing with state and federal regulatory agencies, prior to contracting and every three (3) years thereafter.

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F. CalOptima shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this Policy if the provider is not accredited, as applicable.

G. CalOptima shall ensure that the OP is actively enrolled in Medi-Cal and has not opted-out of Medicare, as applicable.

~~H. On a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List and Medi-Cal Suspended & Ineligible (S&I). CalOptima shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.~~

H. Upon initial assessment, reassessment, and on a monthly basis, CalOptima shall confirm the Medi-Cal and Medicare participation status of the OP.

I. If CalOptima declines to include an OP in the CalOptima provider network, CalOptima shall notify, in writing, such OP within sixty (60) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

J. CalOptima shall maintain the confidentiality of credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

~~K. The CalOptima Board of Directors shall review and approve this Policy periodically.~~

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section ~~II.H~~III.C. of this Policy.

2. The OP shall submit an application, signed and dated by an authorized official of the OP, along with the following supplemental documentation:

a. Confirmation that the OP is in compliance with any other applicable state or federal requirements, and possess a business license (or business tax certificate), as applicable;

b. Accreditation and/or Government Issued Certification, as applicable. ~~Issuing bodies include, but are not limited to:~~

i. The Joint Commission (TJC): A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing and audiology certification;

vii. Durable Medical Equipment (DME) or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS);

viii. Commission on ~~accreditation~~Accreditation of ~~ambulance services~~Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, Durable Medical Equipment prosthetics orthotic suppliers, pharmacies; and

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging providers, and procedure-based modalities.

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals.

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of End State Renal Disease Facilities.

c. If an OP is not accredited, the OP may submit evidence of an on-site quality review by the state, CMS, or similar agency, or CalOptima must provide evidence of on-site quality review. The on-site quality review must include the criteria used for the assessment, and the process for ensuring that the providers credential their Practitioners. The State, CMS, or a similar agency, quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima shall conduct its own onsite quality review.

d. Certificate of current liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable:

i. General/Commercial Liability Insurance;

ii. Professional liability;

iii. Worker's Compensation Insurance.

e. A copy of any history of sanctions, preclusions, exclusions, suspensions or terminations from Medicare and/or Medi-Cal, as applicable.

f. Active enrollment in Medi-Cal and has not opted-out of Medicare , if applicable;

g. A copy of the organization's Quality Plan, if applicable;

h. Staff roster and copy of all staff certifications, or licensure, if applicable;

i. A valid Type 2 National Provider Identifier (NPI) number;

j. IRS Form SS-4, if applicable; and

k. A current W-9.

3. CalOptima shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free-Standing Urgent Care centers providing services to CalOptima Members pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

B. OP Re-assessment

1. CalOptima shall reassess an OP at least every three (3) years after initial assessment. At the time of re-assessment, CalOptima shall:

a. Collect and verify, at a minimum, all of the information required for initial assessment, as set forth in Section III.A. of this Policy; and

b. Incorporate the following data in the decision-making process:

i. Quality review activities, including but not limited to, information from:

a) DHCS, CMS, or another agency, as applicable;

b) CalOptima quality review results, including, but not limited to, Grievances, Appeals, Potential Quality Issue (PQI) cases, and Compliance cases, as applicable;

c) Review of Facility Site Review (FSR) or Physical Accessibility Review Survey (PARS) results, as applicable; and

d) Review of Medical Records, as applicable.

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

2. CalOptima shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima.

C. Upon initial assessment, reassessment, and on a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.

D. Credentialing Peer Review Committee (CPRC)

1. ~~CalOptima shall designate a~~ CalOptima's CPRC ~~that uses a peer review process to~~shall make recommendations and decisions regarding ~~CalOptima's provider network~~an OP's eligibility to participate in CalOptima programs through the peer review process, as necessary.

2. Completed OP files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

   a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment has occurred, and confirmation that the OP is in good standing with state and federal regulatory agencies.

      i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve an OP's assessment and re-assessment file, and deem the file clean.

      ii. ~~Approved, clean~~Clean file lists approved by a medical director shall be presented at the CPRC for final approval and reflected in the meeting minutes.

   b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

      i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the provider submits all the required information.

      ii. CPRC minutes shall reflect thoughtful consideration of information presented in the file.

      iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

3. The CPRC shall make recommendations ~~based~~ on the OP's ability to ~~deliver services~~participate in CalOptima programs based on the information ~~collected from the file review process~~reviewed as specified in this Policy.

   a. The CalOptima Quality Improvement Department shall send the OP, or applicant, a decision letter, within sixty (60) calendar days of the ~~Initial~~ decision~~:~~ indicating:

i. Acceptance;

ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

4. Upon acceptance of the participation application, the CalOptima Quality Improvement Department shall generate a provider profile and forward the provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and provider data into CalOptima's core business system, which updates pertinent information into the online Provider Directory.

IV. ATTACHMENT(S)

A. Organizational Provider Application
B. Onsite Quality Review Tool

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy GG.1607Δ: Monitoring Adverse Actions
I. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
J. CalOptima Policy HH.1101: CalOptima Provider ~~Compliant~~Complaint
K. CalOptima Policy MA.9006: Provider Complaint Process
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
O. California Evidence Code, §1157
P. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424~~,~~ and 431 ~~and 455.450~~
Q. Title 45, Code of Federal Regulations, ~~§~~Part 455
R. Title 42, United States Code, §1320a-7(a)
S. Title XVIII and XIV of the Social Security Act
T. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/15/2020	Department of Health Care Services (DHCS)

~~None to Date~~

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018 ~~06/04/2020~~	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651Δ	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1651Δ	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A ~~request by the Member or the Member's Authorized Representative for~~ review by CalOptima of ~~any decision to deny, modify,~~an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or ~~discontinue~~level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service~~.~~; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a provider to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
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.

Term	Definition
Durable Medical Equipment (DME)and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS):	~~Durable~~Medi-Cal & OneCare Connect: Medically Necessary medical equipment ~~means equipment~~that is prescribed ~~by a licensed practitioner to meet medical equipment needs of~~for the Member ~~that~~by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home. OneCare: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. ~~1.~~4. Is appropriate for use in or out of the patient's home.
Facility Site Review	An on-site inspection of primary care sites to evaluate the capacity or continuing capacity of a site to support the delivery of quality health care services using the DHCS Facility Site Review (FSR), Medical Record Review (MRR) or Physical Accessibility Review Survey (PARS) tools.

Term	Definition
Grievance	~~An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.~~Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
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 Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such ~~as~~, but not limited to: ~~hospitals~~, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, ~~and~~ portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.

Term	Definition
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers
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	Any person or institution that furnishes Covered Services.
Re-Assessment	The process by which provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.

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Policy:	GG.1651Δ
Title:	**Assessment and Re-Assessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima evaluates and determines an Organizational Provider's (OPs) eligibility to participate in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines for evaluation of OPs participation eligibility in CalOptima programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima may delegate the assessment and reassessment of OPs to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to assess and reassess OPs to participate in its CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and shall actively participate in the assessment and reassessment of an OP.

D. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima's findings for determining an OP's participation in CalOptima's provider network.

E. CalOptima shall require that the OP be successfully assessed, including confirmation that the OP is in good standing with state and federal regulatory agencies, prior to contracting and every three (3) years thereafter.

F. CalOptima shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this Policy if the provider is not accredited, as applicable.

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G. CalOptima shall ensure that the OP is actively enrolled in Medi-Cal and has not opted-out of Medicare, as applicable.

H. Upon initial assessment, reassessment, and on a monthly basis, CalOptima shall confirm the Medi-Cal and Medicare participation status of the OP.

I. If CalOptima declines to include an OP in the CalOptima provider network, CalOptima shall notify, in writing, such OP within sixty (60) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

J. CalOptima shall maintain the confidentiality of credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.C. of this Policy.

2. The OP shall submit an application, signed and dated by an authorized official of the OP, along with the following supplemental documentation:

   a. Confirmation that the OP is in compliance with any other applicable state or federal requirements, and possess a business license (or business tax certificate), as applicable;

   b. Accreditation and/or Government Issued Certification, as applicable.

      i. The Joint Commission (TJC): A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

      ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

      iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

      iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

      v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing and audiology certification;

vii. Durable Medical Equipment (DME) or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, Durable Medical Equipment prosthetics orthotic suppliers, pharmacies; and

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging providers, and procedure-based modalities.

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals.

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of End State Renal Disease Facilities.

c. If an OP is not accredited, the OP may submit evidence of an on-site quality review by the state, CMS, or similar agency, or CalOptima must provide evidence of on-site quality review. The on-site quality review must include the criteria used for the assessment, and the process for ensuring that the providers credential their Practitioners. The State, CMS, or a similar agency, quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima shall conduct its own onsite quality review.

d. Certificate of current liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable:

i. General/Commercial Liability Insurance;

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e. A copy of any history of sanctions, preclusions, exclusions, suspensions or terminations from Medicare and/or Medi-Cal, as applicable.

f. Active enrollment in Medi-Cal and has not opted-out of Medicare , if applicable;

g. A copy of the organization's Quality Plan, if applicable;

h. Staff roster and copy of all staff certifications, or licensure, if applicable;

i. A valid Type 2 National Provider Identifier (NPI) number;

j. IRS Form SS-4, if applicable; and

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3. CalOptima shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free-Standing Urgent Care centers providing services to CalOptima Members pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

B. OP Re-assessment

1. CalOptima shall reassess an OP at least every three (3) years after initial assessment. At the time of re-assessment, CalOptima shall:

a. Collect and verify, at a minimum, all of the information required for initial assessment, as set forth in Section III.A. of this Policy; and

b. Incorporate the following data in the decision-making process:

i. Quality review activities, including but not limited to, information from:

a) DHCS, CMS, or another agency, as applicable;

b) CalOptima quality review results, including, but not limited to, Grievances, Appeals, Potential Quality Issue (PQI) cases, and Compliance cases, as applicable;

c) Review of Facility Site Review (FSR) or Physical Accessibility Review Survey (PARS) results, as applicable; and

d) Review of Medical Records, as applicable.

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

2. CalOptima shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima.

C. Upon initial assessment, reassessment, and on a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima's CPRC shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima programs through the peer review process, as necessary.

2. Completed OP files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

    a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment has occurred, and confirmation that the OP is in good standing with state and federal regulatory agencies.

        i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve an OP's assessment and re-assessment file, and deem the file clean.

        ii. Clean file lists approved by a medical director shall be presented at the CPRC for final approval and reflected in the meeting minutes.

    b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

        i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the provider submits all the required information.

        ii. CPRC minutes shall reflect thoughtful consideration of information presented in the file.

        iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

3. The CPRC shall make recommendations on the OP's ability to participate in CalOptima programs based on the information reviewed as specified in this Policy.

    a. The CalOptima Quality Improvement Department shall send the OP, or applicant, a decision letter, within sixty (60) calendar days of the decision indicating:

        i. Acceptance;

        ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

4. Upon acceptance of the participation application, the CalOptima Quality Improvement Department shall generate a provider profile and forward the provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and provider data into CalOptima's core business system, which updates pertinent information into the online Provider Directory.

IV. ATTACHMENT(S)

A. Organizational Provider Application
B. Onsite Quality Review Tool

V. REFERENCE(S)

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J. CalOptima Policy HH.1101: CalOptima Provider Complaint
K. CalOptima Policy MA.9006: Provider Complaint Process
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
O. California Evidence Code, §1157
P. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
Q. Title 45, Code of Federal Regulations, Part 455
R. Title 42, United States Code, §1320a-7(a)
S. Title XVIII and XIV of the Social Security Act
T. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/15/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2018	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651Δ	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1651Δ	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a provider to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
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.

Term	Definition
Durable Medical Equipment (DME)and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS);	Medi-Cal & OneCare Connect: Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home. OneCare: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	An on-site inspection of primary care sites to evaluate the capacity or continuing capacity of a site to support the delivery of quality health care services using the DHCS Facility Site Review (FSR), Medical Record Review (MRR) or Physical Accessibility Review Survey (PARS) tools.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.

Term	Definition
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 Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	A beneficiary enrolled in a CalOptima program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers
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	Any person or institution that furnishes Covered Services.
Re-Assessment	The process by which provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.

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Applicant Tax ID:_____

Organizational Provider (OP)
Quality Assessment Application
and Survey of Specialties and Services

The following application is for organizations which intend to contract with CalOptima. Upon approval, organization then becomes eligible contract should CalOptima be in need of the provider type or services organization provides. Please complete application as accurately and completely as possible. Inclomplete applications will not be accepted. In the event organization is assigned with either a moderate or high risk level, CalOptima may perform an on-site visit.

Name of Organization:			
DBA (If Applicable):			
Billing NPI:		**Tax ID:**	
Business Type:	[ ] LLC	[ ] Corporation	[ ] LP

Line of Business Intended to Contract as:

[ ] CalMediConnect	[ ] Medi-Cal	[ ] OneCare
CalOptima Program(s)	[ ] Behavioral Health	[ ] PACE	[ ] MSSP / IHSS

Registrations and Enrollment

Type	ID	Effective Date	Type/Specialty
Medi-Cal Registration/Enrollment			
Medicare Registration/Enrollment			
Medicare (CMS) Certification			
DHCS/California Licensure			
California Children's Services			

Primary Specialty: _____ *select from one listed in 'Organization Specialty" section below*

Organization Type:

[ ] Agency	[ ] Laboratory	[ ] Respite Care
[ ] Ambulatory Care Facility	[ ] Practitioner/Physician Group	[ ] Supplier
[ ] Hospital	[ ] Nursing & Custodial Care Facility	[ ] Transportation Services
[ ] Hospital Unit	[ ] Residential Treatment Facility	[ ] Other

Count of Accreditations Held _____ **Count of Service Addresses** _____

Business/Administrative Information

Business Address

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Business License / Tax Certificate Issued By:

Billing Address

[ ] *Billing is performed by a third party. If so, indicate company name*_____

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Mailing Address

[ ] *Mailing address is the same as the business address*

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Organization's Authorized Official(s)

Authorized Official Name			
Title			
Email Address		**Contact Phone**	

If applicable to applicant organization, supply the below contact information. **Please note CalOptima uses email as the primary method for communication.** If a similar role is held by your organization, please enter the individuals information.

	Name	**Email Address**
Practitioner Credentialing Contact		
CEO *(Chief Executive Officer)*		
CAO *(Chief Administration Officer)*		
CMO *(Chief Medical Officer)*		
CFO *(Chief Financial Officer)*		
Director of Nursing		

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Applicant Tax ID:_____

Organization Accreditation or Government Issued Certification *(If more than one is held, complete page 3 for each held)*

Accrediting/Certifying Body	
Identification Number	

[ ] **Check if on-site visit was performed**

Last Survey Date	
Next Survey Date	

Check all which apply below, as it applies to the organization's accreditation or Certification. Data will be used to assist with Member Referrals and Authorizations

Administration

- [ ] Case Management (CM)
- [ ] Credentialing/Staffing (CR)
- [ ] Patient Safety/Plan (PS)
- [ ] Quality Improvement/Plan (QI)
- [ ] Utilization Management (UM)

Programs/Services

- [ ] Ambulatory Care
- [ ] Ambulatory Surgery
- [ ] Anesthesia
- [ ] Aquatic Therapy
- [ ] Behavioral Health
- [ ] Behavioral Health (Home)
- [ ] Canes and Crutches
- [ ] Chronic Kidney Disease
- [ ] Chronic Obstructive Pulmonary Disease
- [ ] Community Integration
- [ ] Comprehensive Cardiac Center
- [ ] Convenient Care
- [ ] CT Scanner
- [ ] Custom Othoses Fabricated
- [ ] Dementia Care
- [ ] Dentistry
- [ ] Diabetes Self Management
- [ ] Diagnostic Imaging
- [ ] Dialysis
- [ ] Donor Center / Testing
- [ ] Durable Medical Equipment
- [ ] EEG/EKG/FMG Lab
- [ ] Emergency Medicine/Department
- [ ] Enteral Nutrients
- [ ] Gastroenterology
- [ ] Gynecology
- [ ] Heart Failure
- [ ] Heart Failure
- [ ] Hip and Knee Replacement

Programs/Services, cont.

- [ ] Home Care
- [ ] Home Health (Aides)
- [ ] Home Health (Non-Hospice)
- [ ] Hospital
- [ ] Hospital (Critical Access)
- [ ] Hospital (Pediatric)
- [ ] Hospital (Psychiatric)
- [ ] Hospital Beds - Electric
- [ ] Hospital Beds - Manual
- [ ] Immunohematology
- [ ] Inpatient Diabetes
- [ ] Inpatient Unit
- [ ] Laboratory (General)
- [ ] Lung Volume Reduction Surgery
- [ ] Magnetic Resonance Imaging (MRI)
- [ ] Medical/Surgical Unit
- [ ] Molecular Testing
- [ ] Nebulizers Equipment
- [ ] Nursing Care
- [ ] Obstetrics
- [ ] Occupational Therapy
- [ ] Office Based Surgery
- [ ] Orthopedic Surgery
- [ ] Out of Hospital Transfusion Administra
- [ ] Out Patient Clinic
- [ ] Trigger Point Injections
- [ ] Palliative Care
- [ ] Palliative Care (Community Based)
- [ ] Patient Lists and Accessories
- [ ] Pediatric Medicine
- [ ] Perform Invasive Procedure
- [ ] Perinatal Care
- [ ] Perioperative Service
- [ ] Personal Care/Support (Non-Hospice)
- [ ] Pharmacy/Dispensary (General)

Programs/Services, cont.

- [ ] Physical Therapy
- [ ] Plastic Surgery
- [ ] Post-Acute Care
- [ ] Primary Care Medical
- [ ] Primary Stroke Center
- [ ] Rehabilitation Services
- [ ] Respiratory Equipment
- [ ] Skilled Nursing (Care)
- [ ] Skilled Nursing (Services)
- [ ] Social Services
- [ ] Social Services (Medical)
- [ ] Speech Language Pathology
- [ ] Stroke (Advance)
- [ ] Stroke (Comprehensive)
- [ ] Supplies
- [ ] Support Surfaces for Beds
- [ ] Thrombectomy-Capable Stroke Center
- [ ] Transfusion Service
- [ ] Ultrasound
- [ ] Ventricular Assist Device
- [ ] Walkers, Canes and Crushes
- [ ] Wheelchairs - Manual (Non-Custom)
- [ ] X-ray
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

Organizational Specialties

( ) Single-specialty ( ) Multi-specialty

Please identify all specialties below which apply to applicant organization in which intentions are to either contract or submit claims for. Additionally, for each identified specialty, also identify if either an accreditation, certification and/or license is held by the applicant for the specialty.

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Agencies			
[ ]	Case Management	251B00000X	[ ]	[ ]
[ ]	Day Training, Developmentally Disabled Services	251C00000X	[ ]	[ ]
[ ]	Home Health	251E00000X	[ ]	[ ]
[ ]	Home Health (subunit)	251E00000X	[ ]	[ ]
[ ]	Home Infusion	251F00000X	[ ]	[ ]
[ ]	Hospice Care, Community Based	251G00000X	[ ]	[ ]
[ ]	Nursing Care	251J00000X	[ ]	[ ]
[ ]	Public Health or Welfare	251K00000X	[ ]	[ ]
[ ]	Community/Behavioral Health	251S00000X	[ ]	[ ]
[ ]	Program of All-Inclusive Care for the Elderly (PACE) Provider Organization	251T00000X	[ ]	[ ]
[ ]	Voluntary or Charitable	251V00000X	[ ]	[ ]
[ ]	Early Intervention Provider Agency	252Y00000X	[ ]	[ ]
[ ]	In Home Supportive Care	253Z00000X	[ ]	[ ]
	Ambulatory Health Care Facilities [Clinic/Center]			
[ ]	Ambulatory Family Planning Facility	261QA0005X	[ ]	[ ]
[ ]	Adult Day Care	261QA0600X	[ ]	[ ]
[ ]	Ambulatory Surgical	261QA1903X	[ ]	[ ]
[ ]	Birthing	261QB0400X	[ ]	[ ]
[ ]	Critical Access Hospital	261QC0050X	[ ]	[ ]
[ ]	Community Health	261QC1500X	[ ]	[ ]
[ ]	Corporate Health	261QC1800X	[ ]	[ ]
[ ]	Dental	261QD0000X	[ ]	[ ]
[ ]	Developmental Disabilities	261QD1600X	[ ]	[ ]
[ ]	Emergency Care	261QE0002X	[ ]	[ ]
[ ]	End-Stage Renal Disease (ESRD) Treatment	261QE0700X	[ ]	[ ]
[ ]	Endoscopy	261QE0800X	[ ]	[ ]
[ ]	Family Planning, Non-Surgical	261QF0050X	[ ]	[ ]
[ ]	Federally Qualified Health Center (FQHC)	261QF0400X	[ ]	[ ]
[ ]	Genetics	261QG0250X	[ ]	[ ]
[ ]	Health Service	261QH0100X	[ ]	[ ]
[ ]	Hearing and Speech	261QH0700X	[ ]	[ ]
[ ]	Infusion Therapy	261QI0500X	[ ]	[ ]
[ ]	Mental Health (Including Community Mental Health Center)	261QM0801X	[ ]	[ ]
[ ]	Adult Mental Health	261QM0850X	[ ]	[ ]
[ ]	Adolescent and Children Mental Health	261QM0855X	[ ]	[ ]
[ ]	Migrant Health	261QM1000X	[ ]	[ ]
[ ]	Magnetic Resonance Imaging (MRI)	261QM1200X	[ ]	[ ]

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
Ambulatory Health Care Facilities [Clinic/Center] (cont.)				
[ ]	Medical Specialty	261QM2500X	[ ]	[ ]
[ ]	Methadone	261QM2800X	[ ]	[ ]
[ ]	Podiatric	261QP1100X	[ ]	[ ]
[ ]	Physical Therapy	261QP2000X	[ ]	[ ]
[ ]	Primary Care	261QP2300X	[ ]	[ ]
[ ]	Pain	261QP3300X	[ ]	[ ]
[ ]	Radiology	261QR0200X	[ ]	[ ]
[ ]	Radiology, Mammography	261QR0206X	[ ]	[ ]
[ ]	Radiology, Mobile Mammography	261QR0207X	[ ]	[ ]
[ ]	Radiology, Mobile	261QR0208X	[ ]	[ ]
[ ]	Outpatient Rehabilitation (mixed specialty - OT,PT,SLP)	261QR0400X	[ ]	[ ]
[ ]	Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	261QR0401X	[ ]	[ ]
[ ]	Rehabilitation, Cardiac Facilities	261QR0404X	[ ]	[ ]
[ ]	Rehabilitation, Substance Use Disorder	261QR0405X	[ ]	[ ]
[ ]	Research	261QR1100X	[ ]	[ ]
[ ]	Rural Health	261QR1300X	[ ]	[ ]
[ ]	Oral and Maxillofacial Surgery	261QS0112X	[ ]	[ ]
[ ]	Ophthalmologic Surgery	261QS0132X	[ ]	[ ]
[ ]	Sleep Disorder Diagnostic	261QS1200X	[ ]	[ ]
[ ]	Urgent Care	261QU0200X	[ ]	[ ]
[ ]	Occupational Medicine	261QX0100X	[ ]	[ ]
[ ]	Oncology	261QX0200X	[ ]	[ ]
[ ]	Oncology, Radiation	261QX0203X	[ ]	[ ]
[ ]	Optometry	152W00000X	[ ]	[ ]
Hospitals				
[ ]	Chronic Disease Hospital	281P00000X	[ ]	[ ]
[ ]	Chronic Disease Hospital [Pediatric]	281PC2000X	[ ]	[ ]
[ ]	Long Term Care Hospital	282E00000X	[ ]	[ ]
[ ]	General Acute Care Hospital	282N00000X	[ ]	[ ]
[ ]	General Acute Care Hospital [Critical Care]	282NC0060X	[ ]	[ ]
[ ]	General Acute Care Hospital [Pediatric]	282NC2000X	[ ]	[ ]
[ ]	General Acute Care Hospital [Rual]	282NR1301X	[ ]	[ ]
[ ]	General Acute Care Hospital [Women's]	282NW0100X	[ ]	[ ]
[ ]	Psychiatric Hospital	283Q00000X	[ ]	[ ]
[ ]	Rehabilitation Hospital	283X00000X	[ ]	[ ]
[ ]	Rehabilitation Hospital [Pediatric]	283XC2000X	[ ]	[ ]
[ ]	Religious Non-Medical Health Care Institution	282J00000X	[ ]	[ ]
[ ]	Special Hospital	284300000X	[ ]	[ ]
[ ]	Military Hospital	286500000X	[ ]	[ ]
[ ]	Military Hospital [General Acute Care Hospital]	2865M2000X	[ ]	[ ]

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
Hospital Units				
[ ]	Epilepsy Unit	273100000X	[ ]	[ ]
[ ]	Psychiatric Unit	273R00000X	[ ]	[ ]
[ ]	Rehabilitation Unit	273Y00000X	[ ]	[ ]
[ ]	Medicare Defined Swing Bed Unit	275N00000X	[ ]	[ ]
[ ]	Rehabilitation, Substance Use Disorder Unit	276400000X	[ ]	[ ]
Laboratories				
[ ]	Military Clinical Medical Laboratory	291900000X	[ ]	[ ]
[ ]	Clinical Medical Laboratory	291U00000X	[ ]	[ ]
[ ]	Dental Laboratory	292200000X	[ ]	[ ]
[ ]	Physiological Laboratory	293D00000X	[ ]	[ ]
Organizations				
[ ]	Exclusive Provider Organization	302F00000X	[ ]	[ ]
[ ]	Health Maintenance Organization	302R00000X	[ ]	[ ]
[ ]	Preferred Provider Organization	305R00000X	[ ]	[ ]
[ ]	Point of Service	305S00000X	[ ]	[ ]
Nursing & Custodial Care Facilities				
[ ]	Assisted Living Facility	310400000X	[ ]	[ ]
[ ]	Intermediate Care Facility, Mental Illness	310500000X	[ ]	[ ]
[ ]	Alzheimer Center (Dementia Center)	311500000X	[ ]	[ ]
[ ]	Custodial Care Facility	311Z00000X	[ ]	[ ]
[ ]	Custodial Care Facility [Adult Care Home]	311ZA0620X	[ ]	[ ]
[ ]	Nursing Facility/Intermediate Care Facility	313M00000X	[ ]	[ ]
[ ]	Skilled Nursing Facility	314000000X	[ ]	[ ]
[ ]	Skilled Nursing Facility [Pediatric]	3140N1450X	[ ]	[ ]
[ ]	Hospice, Inpatient	315D00000X	[ ]	[ ]
[ ]	Intermediate Care Facility, Mentally Retarded	315P00000X	[ ]	[ ]
Residential Treatment Facilities				
[ ]	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320600000X	[ ]	[ ]
[ ]	Residential Treatment Facility, Physical Disabilities	320700000X	[ ]	[ ]
[ ]	Community Based Residential Treatment Facility, Mental Illness	320800000X	[ ]	[ ]
[ ]	Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320900000X	[ ]	[ ]
[ ]	Residential Treatment Facility, Emotionally Disturbed Children	322D00000X	[ ]	[ ]
[ ]	Psychiatric Residential Treatment Facility	323P00000X	[ ]	[ ]
[ ]	Substance Abuse Rehabilitation Facility	324500000X	[ ]	[ ]
[ ]	Substance Abuse Rehabilitation Facility [Pediatric]	3245S0500X	[ ]	[ ]
Respite Care Facility				
[ ]	Respite Care	385H00000X	[ ]	[ ]

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
Suppliers				
[ ]	Blood Bank	331L00000X	[ ]	[ ]
[ ]	Military/U.S. Coast Guard Pharmacy	332000000X	[ ]	[ ]
[ ]	Department of Veterans Affairs (VA) Pharmacy	332100000X	[ ]	[ ]
[ ]	Non-Pharmacy Dispensing Site	332900000X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies	332B00000X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Customized Equipment]	332BC3200X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Dialysis Equipment]	332BD1200X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Nursing Facility Supplies]	332BN1400X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Perenteral & Enteral Nutrition]	332BP3500X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies [Oxygen Equipment & Supplies]	332BX2000X	[ ]	[ ]
[ ]	Eyewear Supplier	332H00000X	[ ]	[ ]
[ ]	Hearing Aid Equipment	332S00000X	[ ]	[ ]
[ ]	Home Delivered Meals	332U00000X	[ ]	[ ]
[ ]	Emergency Response System Companies	333300000X	[ ]	[ ]
[ ]	Pharmacy	333600000X	[ ]	[ ]
[ ]	Pharmacy[Clinic Pharmacy]	3336C0002X	[ ]	[ ]
[ ]	Pharmacy[Community Retail]	3336C0003X	[ ]	[ ]
[ ]	Pharmacy[Compounding Pharmacy]	3336C0004X	[ ]	[ ]
[ ]	Pharmacy[Home Infusion Therapy Pharmacy]	3336H0001X	[ ]	[ ]
[ ]	Pharmacy[Institutional Pharmacy]	3336I0012X	[ ]	[ ]
[ ]	Pharmacy[Long Term Care Pharmacy]	3336L0003X	[ ]	[ ]
[ ]	Pharmacy[Mail Order Pharmacy]	3336M0002X	[ ]	[ ]
[ ]	Pharmacy[Managed Care Organization Pharmacy]	3336M0003X	[ ]	[ ]
[ ]	Pharmacy[Nuclear Pharmacy]	3336N0007X	[ ]	[ ]
[ ]	Pharmacy[Specialty Pharmacy]	3336S0011X	[ ]	[ ]
[ ]	Prosthetic/Orthotic Supplier	335E00000X	[ ]	[ ]
[ ]	Medical Foods Supplier	335G00000X	[ ]	[ ]
[ ]	Organ Procurement Organization	335U00000X	[ ]	[ ]
[ ]	Portable X-ray and/or Other Portable Diagnostic Imaging Supplier	335V00000X	[ ]	[ ]
Transportation Services				
[ ]	Ambulance [Air Transport]	3416A0800X	[ ]	[ ]
[ ]	Ambulance [Land Transport]	3416L0300X	[ ]	[ ]
[ ]	Ambulance [Water Transport]	3416S0300X	[ ]	[ ]
[ ]	Military/U.S. Coast Guard Transport	341800000X	[ ]	[ ]
[ ]	Secured Medical Transport (VAN)	343800000X	[ ]	[ ]
[ ]	Non-emergency Medical Transport (VAN)	343900000X	[ ]	[ ]
[ ]	Transportation Broker	347E00000X	[ ]	[ ]

If specialty is not found in this section please provide the following:

	Specialty	Taxonomy Code *(if known)*
Primary Specialty		
Specialty 2		
Specialty 3		
Specialty 4		
Specialty 5		
Specialty 6		

Section intentionally left blank

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Applicant Tax ID:_____

Service Address(es)	Location 1 of _____

[ ] *Check if location is included in organization's accreditation*

Address Type(s) [ ] After hours [ ] Service Address [ ] Unit

If applicable, alternate location name

Location NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? YES NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name Phone Email

Hours of Operation: [ ] **Check if open 24/7**

Including holidays Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Peri-Natal [ ] Child [ ] Adult

[ ] Infant [ ] Adolescent [ ] Geriatric

Languages Spoken

Enter all languages spoken by Member facing staff

Special Services at Location

Location is Enrolled in Medi-Cal

Telehealth Distant Site

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Applicant Tax ID:_____

Service Address(es)	Location 2 of _____

[ ] *Check if location is included in organization's accreditation*

Address Type(s) [ ] After hours [ ] Service Address [ ] Unit

If applicable, alternate location name

Location/Unit NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? YES NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name Phone Email

Hours of Operation: [ ] **Check if open 24/7**

Including holidays Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Peri-Natal [ ] Child [ ] Adult

[ ] Infant [ ] Adolescent [ ] Geriatric

Languages Spoken

Enter all languages spoken by member facing staff

Special Services at Location

Location is Enrolled in Medi-Cal

Telehealth Distant Site

CalOptima
A Public Agency
Better. Together.

Applicant Tax ID:_____

Service Address(es)	Location 3 of _____

[ ] *Check if location is included in organization's accreditation*

Address Type(s) [ ] After hours [ ] Service Address [ ] Unit

If applicable, alternate location name

Location NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name **Phone** **Email**

Hours of Operation [ ] Check if open 24/7

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Peri-Natal [ ] Child [ ] Adult

[ ] Infant [ ] Adolescent [ ] Geriatric

Languages Spoken

Enter all languages spoken by member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal ☐ Telehealth Distant Site

Attestation

I attest that all of the information submitted by me in this document is true, correct, and complete to the best of my knowledge and belief. I understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of participation or cause for summary dismissal from CalOptima or be subject to applicable State or Federal penalties for perjury. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

You and your agents must meet CalOptima's Eligibility Status requirements. This means that you and your agents must be eligible to participate in Federal and/or State healthcare programs, including the Medi-Cal Program (not currently suspended, excluded or otherwise ineligible and not excluded at any time based on a mandatory exclusion in 42 U.S.C. 1396a-7(a), hold appropriate government issued licensures, not held liable in any criminal or civil proceedings for fraud waste or abuse and not convicted of a criminal offense related to healthcare in the prior seven (7) years).

Persons or entities that do not meet the Eligibility Status requirements are not eligible to receive reimbursement from CalOptima. As referred to in this application which also serves as CalOptima's registration form, "your agents" means all of your employees, subcontractors, and/or agents furnishing items or services to CalOptima and its members.

You and your agents must comply with any executed contracts with CalOptima, CalOptima's Compliance Program, all CalOptima Policies and Procedures applicable to items and/or services you furnish to CalOptima and its members.

Name of Authorized Official

Title of Authorized Official

Signature of Authorized Official

Date

Email Address

Submit completed application and supplemental documents to

OrgProviderQuality@CalOptima.org

Organizational Provider/ Site Review Tool & Corrective Action Plan					Survey Date:	
Type of Organizational Provider					**Reviewer Information**	
	Total Number of on-site staff =				**Reviewer Name:**	
Name of Organization:	Physician(s)		NP(s)			
	RN(s)		PA(s)		**Reviewer's Organization Name:**	
Address, City, ST, ZIP:	LVN(s)		RD(s)			
	Clerical (s)		LCSW/SW(s)		**Reviewer Phone:**	
Phone:	Other:					
	Site Visit Purpose				**Reviewer Email:**	
Fax Number:		**Initial Assessment/ Re-Assessment (Mark X if applicable)**				
		Complaint Review (Mark X if applicable)				
Administrator Name:		**CAP Follow-up 1 (Date of this Follow-up)**			**Corrective Action Plan**	
		CAP Follow-up 2 (Date of this Follow-up)			**Scores below [enter % per your organizations policy] require a CAP.**	
Nursing Director Name:						
		Other:			**[Optional may define other CAP requirements here] Critical element deficiency requires CAP regardless of score.**	
Medical Director Name:						

Assessment Summary				
		Points Earned	Actual Available Points*	Possible Available Points*
A.	Administrative Services	0	0	4
B.	Policies & Procedures	0	0	10
C.	Personnel	0	0	4
D.	Environment	0	0	9
E.	Environment - Emergency Plan	0	0	7
F.	Infection Control	0	0	11
G.	QAPI	0	0	5
H.	QAPI - Documents	0	0	5
I.	Medical Records	0	0	6

CAP INFORMATION	
Next Follow-up Date:	
Next Follow-up Date:	
CAP Closure Date:	
In-person visit	
Documentation Req'd	
Telephone follow-up	

Facility Score	
Total Points Earned:	0
Total Points Available:*	0
Total Score :	#DIV/0!

Name of Organization:	Date of Survey:			Facility Audit Tool
A. Administrative Services	**YES**	**NO**	**N/A**	**COMMENTS**
1. Organization has local, state License/Certification as needed. Information is appropriately posted.				
2. There is an established organizational structure with defined functions and responsibilities. (This may be an organizational chart or other document)				
3. The OP clearly identified contracted services and temporary staff.				
4. There is access to interpreter services for patients with limited English proficiency and those with hearing impairments.				
B. Policies & Procedures	**YES**	**NO**	**N/A**	**COMMENTS**
1. Medical Record keeping				
2. Infection Control				
· Qualified Infection Control Professional				
· Vaccinations encouraged and monitored				
· Personal Protective Equipment				
· Hazardous waste				
3. Equipment Maintenance				
4. Emergency Procedures				
5. Patient Rights: The patients' rights are protected according to the regulations appropriate for the facility. This may include the right to give informed consent (in the appropriate language) ; the right to privacy and the privacy of personally identifiable healthcare information; and the right to report grievances , abuse or neglect.				
6. There is a policy & procedure regarding licensure & credentialing and privileging of staff.				
7. There is evidence that the policies & procedures have been reviewed, revised, and approved. periodically				

C. Personnel	YES	NO	N/A	COMMENTS
1. Physician(s) and other LIP(s) are credentialed and privileged according to policy and procedures.				
2. Rendering and Supervising Personnel have License, Training, and Education on file.				
3. There is evidence that agency/contracted staff are appropriately reviewed.				
4. There is documentation of staff education and training.				

Name of Organization:	Date of Survey:			Facility Audit Tool
D. Environment	**YES**	**NO**	**N/A**	**COMMENTS**
1. There are accessible exits which are clearly marked and emergency evacuation routes are posted.				
2. There is evidence of sufficient fire protection equipment (smoke detectors, fire extinguishers, fire blankets, etc.) and a record of fire drills.				
3. Medical equipment is clean, in good working condition and inspected according to policy and procedures to assure safety.				
4. There is sufficient handicap parking, access and accommodations within the building.				
5. Bio hazard waste is handled appropriately and there is a contract for its regular disposal.				
6. The facility is clean and the waiting area is of sufficient size to accommodate patients comfortably and to assure privacy during registration.				
7. Life Safety Code waivers (if any) no not adversely affect the operation of the facility.				
8. OP with special requirements (such as Dialysis Centers and Ambulatory surgical centers) follow established guidelines.				
9. Medication refrigerator temperature trending logs are correct and complete per policy and procedure.				

E. Environment - Emergency Plan	**YES**	**NO**	**N/A**	**COMMENTS**
1. The OP has a health care emergency plan in which staff have received training.				
2. If part of the plan, a readily accessible Crash Cart is on site that contains at least the following:				
a. Defibrillator, or AED.				
b. Suction				
c. Airway Management Devices (airways, oxygen masks/cannulas, ambu bag)				
d. Medications (per Medical Emergencies Policy)				
3. Emergency phone numbers posted at nurse's station are current.				
4. Staff with Advance Life Support (ALS) and/or Basic Life Support (BLS) are identified and their certification is current				

Name of Organization:	Date of Survey:			Facility Audit Tool
F. Infection Control Practices	**YES**	**NO**	**N/A**	**COMMENTS**
1. Does the OP have an infection control program based on established Policies and Procedures.				
2. Does the Infection Control program follow recognized guidelines.				
3. Does the OP have a licensed professional qualified to direct the program.				
4. Does the OP have a system to encourage vaccinations and prevent the spread of infections.				
5. Do staff members receive IC training.				
6. Do staff perform good hand hygiene.				
7. Do staff use good injection practices(injectable medication, saline, and other infusates)				
8. Environmental cleaning is appropriate and staff receive training				
9. Point of care devices used and cleaned appropriately.				
10. Proper use of Personal Protective Equipment observed (gloves, gowns, masks, etc.)				
11. Infection Control information is reviewed as part of Quality Assurance Performance Improvement.				

G. Quality Assurance Performance Improvement (QAPI)	**YES**	**NO**	**N/A**	**COMMENTS**
1. Is there a QAPI committee which meets regularly and keeps minutes				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective actions plans, monitored the results of the plans, and made appropriate changes based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports submitted by outside agencies. Corrective action plans are available.				

Name of Orgaization:	Date of Survey:			Facility Audit Tool
H. QAPI Documentation Which Demonstrates Compliance	**YES**	**NO**	**N/A**	**COMMENTS**
1. Designated QA&PI coordinator.				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective action plans, monitored the results of the plans and made changes on based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports from outside agencies. They have copies of the corrective action plans.				

I. Medical Records/BH Review	YES	NO	N/A	COMMENTS
1. The Policies and Procedures must reflect current practices, assure privacy, and include Electronic Medical Records if used. All entries in the medical record follow established policy and procedure.				
2. Admission data is complete, informed consents, H&P and notes are signed and dated.				
3. All known Allergies are noted in the record.				
4. The medical records are uniquely identified to safeguard patient privacy.				
5. Advanced directives and surrogate healthcare decision makers are noted in the record.				
6 . Policy and procedures allow prompt retrieval and long term storage of medical records for the time required by regulation.				

Additional Information	YES	NO	N/A	COMMENTS

Organizational Provider/ Site Review Tool

Corrective Action Plan (CAP) Follow-Up

Name of Organization:	Date of Survey	Reviewer Name:	
	DD/MM/YYY	(Reviewer Name here)	
Deficiency # and Description	**Date of Comment**	**Comments**	**CAP Closed**

Policy:	GG.1655
Title:	**Reporting Provider Preventable Conditions (PPC)**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	
Effective Date:	05/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the method by which CalOptima reports Provider Preventable Conditions (PPC) to the Department of Health Care Services (DHCS).

II. POLICY

A. ~~In~~CalOptima shall report PPC events to DHCS in accordance with Title 42, Code of Federal Regulations (C.F.R), Section 438.3(g~~),~~) and DHCS guidance, including All Plan Letter (APL) 17-009: Reporting Requirements Related to Provider Preventable Conditions~~, CalOptima shall report PPC events to the Department of Health Care Services (DHCS).~~ and Duals Plan Letter (DPL) 17-002: Reporting Requirement Related to Provider Preventable Conditions.

B. CalOptima shall screen claims and Encounter data received from its Health Networks and Network Providers for the presence of PPCs.

C. PPC reports submitted by CalOptima shall include PPCs identified through a review of Encounter and claims data submitted by Health Networks or Network Providers, as well as PPCs reported directly to CalOptima ~~through the DHCS 7107 Form or its equivalent.~~when the Health Network or Network Provider reports via the DHCS portal.

~~1. Network Providers shall submit PPCs to CalOptima in accordance with Section III.B of this Policy.~~

~~2.~~1. Health Networks and Network Providers shall submit PPCs to DHCS in accordance with California Welfare & Institutions Code, Section 14131.11(f) and in a manner specified by DHCS.

~~D. CalOptima shall not issue payment to Medi-Cal providers for the treatment of PPCs.~~

2. Health Networks and Network Providers shall submit PPCs to CalOptima in accordance with Section III.B of this Policy.

~~E.~~D. Health Networks and Network Providers shall report all PPC events, regardless of ineligibility for reimbursement.

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~~F.~~E. CalOptima shall issue a special notice informing Health Networks and Network Providers of the requirement to submit PPCs utilizing DHCS' secure on-line reporting portal.

~~G.~~F. Health Networks and Network Providers shall have policies and procedures, in compliance with State and Federal guidance for PPCs, which are consistent with DHCS All Plan Letter (APL ~~16-011~~) 17-009: Reporting Requirements Related to Provider Preventable Conditions~~,~~ and DPL 17-002: Reporting Requirements Related to Provider Preventable Conditions and their obligations under CalOptima's Health Network Service Agreement.

G. CalOptima shall not issue payment to a Network Provider for the treatment of PPCs, except when the PPC existed prior to the initiation of treatment for the Member by the Network Provider. Overpayment recovery shall be in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

III. PROCEDURE

A. ~~CalOptima's~~The CalOptima Quality Improvement (QI) Department shall review claims and Encounter data submitted by Health Networks and Network Providers for potential PPC events~~.~~, on a monthly basis.

1. CalOptima shall ~~complete~~submit the PPC via the DHCS ~~7107 form~~PPC online portal for any PPC event identified through the screening process ~~and shall submit it in the manner specified by DHCS~~ on a monthly basis.

2. CalOptima shall notify Health Networks and Network Providers of any PPC events identified through the screening process.

B. Network Providers shall report PPC events directly to DHCS in a manner specified by DHCS~~,~~ and shall send secure copies of ~~all DHCS 7107 Forms~~PPC submission to CalOptima's Quality Improvement (QI) Department via e-mail to qualityofcare@caloptima.org or fax to 657-900-1615.

C. CalOptima shall retain copies of all ~~DHCS 7107 Forms submitted.~~PPCs submitted to DHCS, in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.

IV. ATTACHMENTS

Not Applicable
~~A. DHCS Form 7107: Medi-Cal Provider Preventable Conditions (PPC) Reporting Form~~

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
D. CalOptima Policy HH.2022Δ: Record Retention and Access
~~B. CalOptima Policy MA.1005: Hospital Acquired Conditions Reimbursement~~
E. Department of Health Care Services (DHCS) All Plan Letter 17-009: Reporting Requirements Related to Provider Preventable Conditions
~~C.~~F. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-002: Reporting Requirement Related to Provider Preventable Conditions
~~D.~~G. Title 42, Code of Federal Regulations (C.F.R), §§434.6(a)(12), 438.8(g), and 447.26
~~E.~~H. Welfare & Institutions Code, §14131.11

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
06/09/2017	Department of Health Care Services (DHCS)
10/26/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2017	GG.1655	Reporting Provider Preventable Conditions (PPC)	Medi-Cal
Revised	TBD	GG.1655	Reporting Provider Preventable Conditions (PPC)	Medi-Cal ~~OneCare~~ OneCare Connect

IX. GLOSSARY

Term	Definition
Encounter	Any single medically related service rendered by (a) medical provider(s) to a Member enrolled in CalOptima during the date of service. It includes, but is not limited to, all services for which CalOptima incurred any financial liability.
Health Care Acquired Conditions (HCACs)	As defined in ~~Tile~~Title 42 of the Code of Federal Regulations (C.F.R), Section 447.26(b), any one of the following conditions, occurring in any inpatient hospital setting, identified as a Hospital Acquired Condition (HAC) by the Secretary under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act. • Any unintended foreign object retained after surgery • A clinically significant air embolism • An incidence of blood incompatibility • A stage III or stage IV pressure ulcer that developed during the patient's stay in the hospital • A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock • A catheter-associated urinary tract infection • Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity • A surgical site infection following: ▪ Coronary artery bypass graft (CABG) - mediastinitis ▪ Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery ▪ Orthopedic procedures; including spine, neck, shoulder, elbow ▪ Cardiac implantable electronic device procedures • Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement with pediatric and obstetric exceptions • Latrogenic pneumothorax with venous catheterization • • A vascular catheter-associated infection
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.~~health network.
Member	A beneficiary enrolled in a CalOptima Program.
Network Provider	~~A~~For purposes of this Policy, a Provider that subcontracts with CalOptima Direct or a Health Network for the delivery of the Medi-Cal or OneCare Connect Covered Services to Members.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

Term	Definition
Other Provider Preventable Conditions (OPPCs)	As defined in 42 CFR 447.26, a condition occurring in any health care setting that meets the following criteria: 1. Is identified by the State Plan; 2. Is reasonably preventable through the application of procedures supported by evidence-based guidelines; 3. Has negative consequences for the Member; 4. Is auditable; and 5. Includes, at a minimum, the following procedures: • Wrong surgical or other invasive procedure performed on a patient. • Surgical or other invasive procedure performed on the wrong body part. • • Surgical or other invasive procedure performed on the wrong patient.
Provider Preventable Condition (PPC)	A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition," as defined in 42 CFR 447.26(b)

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Policy:	GG.1655
Title:	**Reporting Provider Preventable Conditions (PPC)**
Department:	Medical Management
Section:	Quality Improvement
Interim CEO Approval:	
Effective Date:	05/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the method by which CalOptima reports Provider Preventable Conditions (PPC) to the Department of Health Care Services (DHCS).

II. POLICY

A. CalOptima shall report PPC events to DHCS in accordance with Title 42, Code of Federal Regulations (C.F.R), Section 438.3(g) and DHCS guidance, including All Plan Letter (APL) 17-009: Reporting Requirements Related to Provider Preventable Conditions and Duals Plan Letter (DPL) 17-002: Reporting Requirement Related to Provider Preventable Conditions.

B. CalOptima shall screen claims and Encounter data received from its Health Networks and Network Providers for the presence of PPCs.

C. PPC reports submitted by CalOptima shall include PPCs identified through a review of Encounter and claims data submitted by Health Networks or Network Providers, as well as PPCs reported directly to CalOptima when the Health Network or Network Provider reports via the DHCS portal.

1. Health Networks and Network Providers shall submit PPCs to DHCS in accordance with California Welfare & Institutions Code, Section 14131.11(f) and in a manner specified by DHCS.

2. Health Networks and Network Providers shall submit PPCs to CalOptima in accordance with Section III.B of this Policy.

D. Health Networks and Network Providers shall report all PPC events, regardless of ineligibility for reimbursement.

E. CalOptima shall issue a special notice informing Health Networks and Network Providers of the requirement to submit PPCs utilizing DHCS' secure on-line reporting portal.

F. Health Networks and Network Providers shall have policies and procedures, in compliance with State and Federal guidance for PPCs, which are consistent with DHCS All Plan Letter (APL) 17-009: Reporting Requirements Related to Provider Preventable Conditions and DPL 17-002:

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Reporting Requirements Related to Provider Preventable Conditions and their obligations under CalOptima's Health Network Service Agreement.

G. CalOptima shall not issue payment to a Network Provider for the treatment of PPCs, except when the PPC existed prior to the initiation of treatment for the Member by the Network Provider. Overpayment recovery shall be in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

III. PROCEDURE

A. The CalOptima Quality Improvement (QI) Department shall review claims and Encounter data submitted by Health Networks and Network Providers for potential PPC events, on a monthly basis.

1. CalOptima shall submit the PPC via the DHCS PPC online portal for any PPC event identified through the screening process on a monthly basis.

2. CalOptima shall notify Health Networks and Network Providers of any PPC events identified through the screening process.

B. Network Providers shall report PPC events directly to DHCS in a manner specified by DHCS and shall send secure copies of PPC submission to CalOptima's Quality Improvement (QI) Department via e-mail to qualityofcare@caloptima.org or fax to 657-900-1615.

C. CalOptima shall retain copies of all PPCs submitted to DHCS, in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
D. CalOptima Policy HH.2022Δ: Record Retention and Access
E. Department of Health Care Services (DHCS) All Plan Letter 17-009: Reporting Requirements Related to Provider Preventable Conditions
F. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-002: Reporting Requirement Related to Provider Preventable Conditions
G. Title 42, Code of Federal Regulations (C.F.R), §§434.6(a)(12), 438.8(g), and 447.26
H. Welfare & Institutions Code, §14131.11

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
06/09/2017	Department of Health Care Services (DHCS)
10/26/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2017	GG.1655	Reporting Provider Preventable Conditions (PPC)	Medi-Cal
Revised	TBD	GG.1655	Reporting Provider Preventable Conditions (PPC)	Medi-Cal OneCare Connect

IX. GLOSSARY

Term	Definition
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Health Care Acquired Conditions (HCACs)	As defined in Title 42 of the Code of Federal Regulations (C.F.R), Section 447.26(b), any one of the following conditions, occurring in any inpatient hospital setting, identified as a Hospital Acquired Condition (HAC) by the Secretary under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act. • Any unintended foreign object retained after surgery • A clinically significant air embolism • An incidence of blood incompatibility • A stage III or stage IV pressure ulcer that developed during the patient's stay in the hospital • A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock • A catheter-associated urinary tract infection • Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity • A surgical site infection following: ▪ Coronary artery bypass graft (CABG) - mediastinitis ▪ Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery ▪ Orthopedic procedures; including spine, neck, shoulder, elbow ▪ Cardiac implantable electronic device procedures • Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement with pediatric and obstetric exceptions • Latrogenic pneumothorax with venous catheterization • A vascular catheter-associated infection
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.
Member	A beneficiary enrolled in a CalOptima Program.
Network Provider	For purposes of this Policy, a Provider that subcontracts with CalOptima Direct or a Health Network for the delivery of the Medi-Cal or OneCare Connect Covered Services to Members.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

Term	Definition
Other Provider Preventable Conditions (OPPCs)	As defined in 42 CFR 447.26, a condition occurring in any health care setting that meets the following criteria: 1. Is identified by the State Plan; 2. Is reasonably preventable through the application of procedures supported by evidence-based guidelines; 3. Has negative consequences for the Member; 4. Is auditable; and 5. Includes, at a minimum, the following procedures: • Wrong surgical or other invasive procedure performed on a patient. • Surgical or other invasive procedure performed on the wrong body part. • Surgical or other invasive procedure performed on the wrong patient.
Provider Preventable Condition (PPC)	A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition," as defined in 42 CFR 447.26(b)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 9, 2022
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

3. Receive and File 2021 CalOptima Quality Improvement Evaluation, and Recommend Board of Directors Approval of the 2022 CalOptima Quality Improvement Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Marie Jeannis, R.N., M.S.N., CCM, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Actions

- Receive and File 2021 CalOptima Quality Improvement Program Evaluation, and
- Approval of the 2022 Quality Improvement Program

Background

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service 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. The QI Program 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.

CalOptima's QI Program is reviewed, evaluated, and approved annually by the Board of Directors. The QI Program defines the structure within which QI activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members.

The 2021 Quality Improvement Program Evaluation (QI Evaluation) analyzes the core clinical and service indicators to determine if the 2021 QI Program has achieved its key performance goals during the year.

CalOptima had the following achievements in 2021:

- July 2021 – Achieved National Committee of Quality Assurance (NCQA) Accreditation through 2024
- September 2021 – Received a 4 out of 5 NCQA's Medicaid Health Plan rating
- September 2021 – Received mPulse award for Achieving Health Equity related to health care innovation
- September 2021 – Received Orange County Chapter of the Public Relations Society of America's Award of Excellence for COVID-19 response

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- October 2021 – CalOptima PACE program recognized by Assemblywoman Cottie Petrie-Norris for use of telehealth technology
- November 2021 – Received Department of Health Care Services (DHCS) 2021 Consumer Satisfaction Award – Adult (for large scale health plan)

In 2021, CalOptima remained committed to innovative approaches to member engagement. CalOptima expanded member engagement and outreach strategies to include vaccination incentives, on-site member events, collaboration with community partners in addition to direct mailings, email, and mobile texting.

Discussion

CalOptima staff has updated the 2022 QI Program and QI Workplan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

The 2022 QI Program is based on the Board-approved 2021 QI Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards and CalOptima's strategic initiatives.

The revisions are summarized as follows:

1. Updated existing program initiatives to align with health equity and current operational practices
2. Added new programs and initiatives:
    - DHCS Comprehensive Quality Strategy
    - Health Equity Framework
    - CalAIM effective 1/1/2022
3. Added Medi-Cal Rx pharmacy administration change
4. Updated data, roles, and network hierarchies
5. Removed PACE from the QI Program as PACE has its own Quality Improvement Committee and no longer reports to QIC

The 2022, the CalOptima QI Program and Work Plan will be flexible and able to align with new strategic goals and objectives as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

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2022 QI Program Recommendations:

1. Incorporate social determinants of health (SDOH) and health equity in targeted quality initiatives
2. Collaborate with external stakeholders and partners in the comprehensive assessment of our members
3. Develop robust community-based interventions using analytical tools, such as geomapping
4. Strategize and streamline member outreach by using multiple modes of communication
5. Expand collaboration on quality initiatives with health networks
6. Implement Enhanced Care Management (ECM) and Community Supports as part of California Advancing and Innovating Medi-Cal (CalAIM) Program
7. Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic
8. Align QI Program with DHCS 2022 Comprehensive Quality Strategy

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

Fiscal Impact

The recommended action to approve the 2022 QI Program has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2021-22 Operating Budget. Staff will include updated expenditures for the period of July 1, 2022, through December 31, 2022, in the FY 2022-23 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2021 Quality Improvement Program Evaluation
2. 2022 Quality Improvement Program and Work Plan DRAFT FINAL (Redline version)
3. Proposed 2022 Quality Improvement Program and Work Plan DRAFT FINAL (Clean version)
4. PowerPoint Presentation: 2021 QI Evaluation, 2022 QI Program and Work Plan

/s/ Michael Hunn *03/04/2022*
Authorized Signature **Date**

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2021

QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

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2021 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard Pitts, D.O., Ph.D. **Date**

Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

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

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2021 Quality Improvement Evaluation of Overall Program Effectiveness

EXECUTIVE SUMMARY

The 2021 Quality Improvement (QI) Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved key performance goals during the year. This evaluation focuses on quality activities initiated during measurement year 2020, which impacted results in 2021, as well as activities undertaken during the first three quarters of the 2021 calendar year to improve health care and services available to CalOptima members.

The final 2021 QI Work Plan, with the full calendar year results, will be presented as a separate document in Q1 2022 to the Quality Improvement Committee (QIC). The 2021 QI Program Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2022 QI Program and its Work Plan.

The year 2021 continued to be unprecedented as a result of the COVID-19 pandemic and the ongoing public health emergency that began in 2020. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance documents with flexibility in regulations addressing member access to care during the pandemic. DHCS issued All Plan Letter (APL) 20-022, COVID-19 Vaccine Administration, to provide support in the delivery of vaccines to Medi-Cal members.

In December 2020, when the COVID-19 vaccine became available, CalOptima pivoted quickly to develop an equitable strategy to assist our members in obtaining vaccines. In January 2021, CalOptima's Board of Directors approved a CalOptima Vaccine Incentive Program, which provided a $25 non-monetary incentive to members, per vaccine dose, to encourage vaccination. CalOptima also collaborated with Orange County Health Care Agency on the Vaccine Equity Pilot Program, to directly allocate COVID-19 vaccine doses to health network providers and community health centers. CalOptima developed a strategic plan for member engagement and outreach and supported vaccination clinics for diverse communities to address vaccine hesitancy. In September 2021, CalOptima enrolled in the DHCS COVID-19 Vaccination Incentive Program to improve Medi-Cal members' vaccination rates across the state of California. Although CalOptima made great strides in vaccination during 2021, CalOptima is committed to continuing member outreach, targeting disproportionately affected communities and increasing vaccination rates until community immunity is reached.

In 2021, the QI strategy aligned with CalOptima's strategic priorities with a focus on member engagement, access to care and quality outcomes. CalOptima remained focused on advancing QI initiatives to achieve 2021 QI goals and objectives to provide members with access to quality health care services. CalOptima also adopted a strong Plan-Do-Study-Act (PDSA) approach to developing initiatives in 2020 that continued into 2021. These initiatives are focused on long-term improvement efforts for selected high-priority measures. In 2022, based on the 2021 QI Program Evaluation, QI will continue to support a strategy, as identified in the 2022 QI Program, that aligns with

CalOptima's strategic priorities and regulatory requirements and focuses on activities and incentives that will improve member engagement, access to care and quality outcomes.

2021 ACHIEVEMENTS

Awards and Recognitions

- **July 2021:** NCQA renewed CalOptima's Accreditation through 2024. CalOptima was awarded 100% of the allowable points.
- **September 2021:** 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 a rating higher than 4 out of 5. Nationwide, only 16 of the 185 Medicaid plans reviewed scored higher.
- **September 2021**: CalOptima was honored for Achieving Health Equity, by mPulse Mobile, a digital engagement solution company for the health care industry. Winners of this award are recognized as achieving impressive results related to health care innovation, outcomes and health care equity among patient populations. CalOptima was recognized for promoting COVID-19 vaccination through the use of mPulse Mobile to reach Medi-Cal members via texting in seven languages. The campaign promoted pandemic safety and vaccination, including programs tailored to specific geolocations and helped homebound members access in-home vaccinations.
- **September 2021:** Assemblywoman Cottie Petrie-Norris recognized CalOptima's Program of All-Inclusive Care for the Elderly (PACE), particularly the use of telehealth technology for more than 400 participants, with an Assembly Resolution for the program's contributions to Orange County seniors over the past eight years.
- **October 2021:** CalOptima's Communications team was honored with the Orange County Chapter of the Public Relations Society of America's (OCPRSA) Award of Excellence in the category of COVID-19 Response Crisis Communications/Issues Management Programs. The award recognizes CalOptima's COVID-19 prevention and vaccination campaigns, which launched in mid-2020 and early 2021, respectively. The campaigns used newspaper, radio, video, social media, and other formats to provide reliable COVID-19 resource information to members and providers as well as inform the community about COVID-19 vaccine availability.
- **November 2021:** CalOptima received the 2021 Consumer Satisfaction Award – Adult for large-scale health plans from DHCS. The award is based on adult responses to the CAHPS survey, a standardized method health plans use to collect information about members' experience with their health plan and provider services.

Quality Achievements: Review of 2021 Recommendations

CalOptima achieved many of organizational objectives in 2021:

1. Received NCQA Accreditation for the fourth consecutive survey renewal.
2. Continued and expanded health rewards to members for receiving a COVID-19 vaccine.
3. Intensified targeted member outreach by using multiple modes of communications per members' preference, through website, direct mailings, email, member outreach calls,

mobile texting, on-site member outreach and member engagement activities, especially in support of COVID-19 vaccination.

4. Implemented new measures to the Pay for Value (P4V) program for Measurement Year (MY) 2021 for Behavioral Health (BH) Applied Behavior Analysis (ABA) services to help drive improvement in these measures.
5. Prioritized data bridge efforts to improve data exchanges, both at the health network level and plan level in anticipation of many hybrid measures converting to administrative measures. Continued data mining efforts to continuously identify and close data gaps. Areas of focus for MY2021 included improving access to electronic medical record systems and remedying the lab data not currently available through limited contract data exchanges.
6. Expanded Virtual Care Strategy to increase access to care for members, such as BH Virtual Care visits, and telehealth for CalOptima PACE.
7. Continued to partner with UCI on the Orange County Nursing Home COVID-19 Prevention Program to create online toolkits, videos, posters and resources as well as offer webinars and consultative sessions to help stop the spread of COVID-19 in nursing homes.
8. Continued to offer the Post-Acute Infection Prevention Quality Incentive (PIPQI) to nursing facilities who administer the Chlorhexidine (CHG) antiseptic soap in order to reduce the number of nosocomial infections and hospitalizations related to infections for Long-Term Care (LTC) members.

For 2021, CalOptima had adequate staffing and resources and a well-defined quality committee structure in place to meet the required needs of the QI Program. The QI Program structure includes a Quality Improvement Committee (QIC), with several subcommittees reporting to the QIC, which included the Whole-Child Model Clinical Quality Committee (WCM CAC), Utilization Management Committee (UMC), Credentialing and Peer Review Committee (CPRC), Member Experience Committee (MEMX), and Grievance Appeal and Resolution (GARS) Committee. The QIC had exceptional participation from external and internal practitioners as well as staff.

In 2021, CalOptima implemented a robust Population Health Management (PHM) strategy to focus on health disparities and equity. PHM implemented a targeted approach to member outreach that included a focus on interventions for diverse populations and communities, ranging from cancer screenings to managing members with multiple complex conditions. The program had strong member and provider engagement, which was monitored on a quarterly basis. In response to the COVID-19 pandemic and amplification of health disparities for people of color, CalOptima conducted a population segment analysis based on race and ethnicity. The population segment analysis results and opportunities to improve health equity were incorporated in the 2021 QI Program.

In 2022, based on the 2021 QI Program Evaluation, CalOptima will continue its PHM strategy in alignment with CalOptima's strategic priorities to focus on activities and incentives that will improve member engagement, access to care and quality outcomes.

RECOMMENDATIONS FOR 2022

This past year continued to bring uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that has impacted lives locally, nationally and globally. The CalOptima QI Program and Work Plan for 2022 will be flexible to align with the new strategic goals and objectives

as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

Based on the 2021 QI Program Evaluation, in addition to continuing to advance CalOptima's mission and improve quality outcomes of members, we recommend the following initiatives and projects to drive improvements that impact members.

1. Incorporate SDOH factors and analysis of health disparities in the strategic plan for targeted quality initiatives.
2. Collaborate with external stakeholders and partners in comprehensive assessments of our members.
3. Develop robust community-based interventions using analytical tools, such as geomapping in collaboration with community partners and entities that have a good understanding of the target population barriers and behaviors.
4. Strategize and streamline member outreach by using multiple modes of communication via contracted external vendors, including through website, direct mailings, email, Interactive Voice Response (IVR) calls, mobile texting, targeted social media campaigns and robocall technology.
5. Expand collaboration on quality initiatives in partnership with health networks to broaden and expand the reach of coordinated data sharing to close gaps in care.
6. Implement the Enhanced Care Management (ECM) and Community Supports as part of California Advancing and Innovating Medi-Cal (CalAIM).
7. Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic, such as pediatric vaccinations and cancer screenings.
8. Align with proposed DHCS 2022 Comprehensive Quality Strategy, which is a multiple year program.

Evaluation of 2021 Priority Initiatives

COVID-19 VACCINATIONS

CalOptima engaged in a multilayered strategy to encourage COVID-19 vaccinations among members. As of December 31, 2021, 474,715 members have been vaccinated. This equates to 68% of CalOptima members age 16 and older, 67% of members age 12 years and older having received a vaccine, and 59% of members 5 years and older. The rate of vaccination for Whole Child Model members was 47%. Those age 65 years and older had a rate of 80%. Those members in LTC had a rate of 87%. In all age brackets, CalOptima's vaccination was greater than that of the statewide vaccination rate for Medi-Cal members. The highest rate of vaccination by location, 70%–72%, occurred in members living in the cities of Irvine, Garden Grove and Westminster. The highest rate of vaccination by ethnicity was the Asian population at 81%; the lowest rate was among the Black population at 45%.

Member Engagement

CalOptima made several COVID-19 vaccination outreach efforts and provided incentives to members. From May to December 2021, CalOptima organized 10 immunization clinics at various community locations, vaccinating a total of 7,268 people. CalOptima also held special immunization clinics for the frail elderly population located at our PACE clinic, vaccinating 277 participants and 55 staff. Additionally, CalOptima worked with the Coalition of Orange County Community Health Centers and Orange County Health Care Agency to distribute 1,669 gift cards to members experiencing homelessness who had gotten the vaccine.

Texting Strategy

Because Medicaid populations nationwide are vaccinated against COVID-19 at lower rates than the wider population, CalOptima sought to promote vaccination among members who may be vaccine hesitant or face barriers to care. CalOptima engaged mPulse Mobile to roll out a large-scale, COVID-19 texting campaign in seven languages, which was written at the sixth-grade reading level. The campaign promoted pandemic safety and vaccination, including programs tailored to specific geolocations and to help homebound members access in-home vaccinations. Members who responded to the text with vaccine hesitancy were provided with the CDC website for more information. The texting promoted the vaccine events and rewards program, which resulted in 5,318 individuals vaccinated and 2,486 gift cards distributed.

Carenet

CalOptima engaged the services of Carenet to conduct member outreach and encourage members to obtain the COVID-19 vaccination. Carenet was provided a list of 65,100 unvaccinated CalOptima Community Network (CCN) members to perform member outreach, check vaccination status, schedule for vaccination and identify member hesitancy concerns. These calls ran from July–September 2021.

Carenet successfully scheduled COVID-19 vaccination appointments for 8,774 members, which is almost 17% of the population. The member outreach rate ranged from 13%–24%, depending on month. Many members expressed vaccine hesitancy for a variety of reasons. The reasons members provided to Carenet for refusing the vaccine included fear and lack of trust, right to refusal, and political affiliation.

CalOptima has collaborated with the community to combat vaccine misinformation and hesitancy by providing education and engaging with trusted messengers.

CalOptima Homeless Health Initiative

CalOptima's Homeless Health Initiative continued in 2021 with modifications due to the COVID-19 pandemic to maintain telephonic outreach. In 2021, the Clinical Field Team made 244 calls and treated 204 of those outreached, with 133 being CalOptima members. There has been a total of 54 referrals to recuperative care with 34 being CalOptima members. In 2021, CalOptima began establishing regular video office hours at Orange County shelters, with the first location being the Yale Navigation Center. September 2021 brought the first step to re-establish face-to-face engagement with an outreach event at Mary's Kitchen. Collaborative efforts remain in place for coordinating care between housing partners and health networks. The referral process for the Health Homes Program (HHP) was streamlined in 2021, and HHP will sunset on December 31, 2021. All members will transition into CalAIM on January 1, 2022. CalAIM will eventually expand eligibility to a broader set of members and populations.

Since implementation, the Homeless Clinical Access Program (HCAP) has onboarded eight community health centers of which all are still actively participating. Since August 2019, HCAP has been in the field for more than 7,700 hours, paid out $1.5 million in provider incentives and treated 6,346 homeless participants (CalOptima and non-CalOptima members).

Next steps include assessing COVID-19 impacts, determining ongoing needs, and evaluating data and outcomes.

Pay for Value (P4V) Program

The P4V program recognizes outstanding performance and supports ongoing improvement aimed at strengthening CalOptima's mission of providing quality health care. P4V programs are implemented for both Medi-Cal and OneCare Connect, each with separate measures and scoring criteria. All health network and CCN PCPs "in good standing" are eligible to participate in the programs. A new methodology was adopted for MY2020 for the Medi-Cal P4V program, which aims for greater transparency, consistency and administrative simplification. The new Health Network Quality Rating (HNQR) methodology aligns with changes to the measures that are important to CalOptima's NCQA Accreditation status, CMS Star Rating Status, newly required DHCS Managed Care Accountability Set (MCAS) and/or overall NCQA Health Plan Rating. This new methodology was approved by the CalOptima Board of Directors in February 2020. The new methodology more than doubles the per member per month (PMPM) incentive to network providers and health networks for the P4V program, from $2.00 PMPM to $5.00 PMPM.

The HNQR methodology was implemented with MY2020 as the first evaluation year. The program incentivizes all DHCS MCAS measures required to achieve a minimum performance level (MPL) and also includes measures of member satisfaction.

Health network performance scoring and incentive payments on the HEDIS and member satisfaction measures for MY2020 for Medi-Cal and OneCare Connect are currently in progress.

The public health emergency during 2020 had a notable impact on overall health plan performance on both HEDIS and CAHPS scores but the increase in the PMPM payment rate for MY2020 did provide additional incentive to health networks to maintain the performance of most measures at the same level as MY2019 performance. Despite the public health emergency, CalOptima had only two measures that did not achieve the MPL this year.

HEDIS Overview

CalOptima reports HEDIS annually for all lines of business (LOB). HEDIS enables "apples-to-apples" comparison of health plan care across six domains of care:

1. Prevention
2. Access and Availability of Care
3. Utilization
4. Member Experience (CAHPS)
5. Health Plan Descriptive Information (such as membership, language and ethnicity of membership)
6. New measures using Electronic Clinical Data Sources (Adult Immunization Status, Prenatal Immunization Status and Depression Screening)

These results are audited by certified HEDIS Compliance Auditors. All measures fully passed audit, giving CalOptima confidence in the reliability of the results that are used to inform our QI Program and initiatives.

These clinical quality measures are used to evaluate multiple aspects of patient care, including preventive care, coordination of care, patient safety and management of chronic conditions.

Overall Performance Highlights

Medi-Cal

1. Despite the public health emergency in MY2020, CalOptima achieved the MPL for all measures except two: Cervical Cancer Screening (CCS) and Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
2. CalOptima received a 4.0 rating in NCQA's Medicaid Health Plan Ratings 2021. This achievement extended CalOptima's recognition to seven years as one of the top Medi-Cal plans in California.
3. Due to the public health emergency, most of the HEDIS measures for MY2020 are lower compared with the previous year, especially those related to preventive care and requiring office visits and lab tests. However, some measures still showed statistically significant improvement from the prior year. Examples include Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB), Antidepressant Medications Management (AMM).

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) and Use of Opioids from Multiple Providers (UOP).
4. P4V program measures showed improvement, but several are still below the 50th percentile.
5. There is opportunity for improvement in several measures, including CCS, SSD and Follow-Up Care for Children Prescribed ADHD Medication (ADD). These measures will be monitored in the 2022 QI Work Plan.

Key Measures With Opportunity for Improvement: Medi-Cal

Measure	MY2020 Rate	QC Percentile
Cervical Cancer Screening (CCS)	57.60%	33rd
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	71.23%	10th
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase) (ADD)	46.38%	25th

Key Measures With Opportunity for Improvement: OneCare Measures Below 3 Stars

Measure	MY2020 Rate	Star Rating
Care for Older Adults (Functional Status Assessment)	46.98%	1 Star
Statin Therapy for Patients With Cardiovascular Disease — Treatment	71.43%	1 Star
Transitions of Care — Medication Reconciliation	58.96%	2 Stars

Key Measures With Opportunity for Improvement: OneCare Connect Measures Below 3 Stars

Measure	MY2020 Rate	Star Rating
Care for Older Adults (Functional Status Assessment)	50.85%	1 Star
Breast Cancer Screening	61.24%	2 Star
Transitions of Care — Medication Reconciliation	60.10%	2 Star

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the population by implementing broad delivery system, program and payment reforms across Medi-Cal. Two CalAIM components, ECM and Community Supports, will be implemented on January 1, 2022.

CalAIM has three primary goals:

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

ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are flexible, wraparound services that provide a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission.

CalOptima's implementation of ECM and Community Supports will build upon the existing HHP and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima's HHP Community-Based Care Management Entities will transition to become ECM providers. This means that CalOptima and health networks will provide ECM services. ECM providers will be responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

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

Beginning, January 1, 2022, ECM goes live for the following populations of focus:

1. Homeless (adults and children)
2. High utilizer adults
3. Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)
4. Individuals transitioning from incarceration

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

HHP and WPC service providers will continue to provide services under Community Supports as CalOptima works to expand its network of Community Supports providers that have the expertise and capacity to provide the specific services. Members eligible for Community Services must consent to participate and receive services. Beginning January 1, 2022, CalOptima will offer the following four, distinct Community Supports:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Recuperative Care (Medical Respite)

HEALTH EQUITY AND THE SDOH FRAMEWORK

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

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

In response to CalOptima' strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes, designing a comprehensive intervention plan, to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.
PHM will lead CalOptima's Health Equity Framework to ensure that all members have a fair and just opportunity to be as healthy as possible. This will include a long-term effort that includes:

1. Making an organizational commitment to advancing health equity
2. Assessing and building organizational capacity
3. Using data and narrative to describe inequities and their root causes (including SDOH)
4. Designing and implementing strategies to transform practices, policies and systems
5. Tracking progress, sharing lessons and strengthening ongoing capacity to eliminate health inequities

CANCER SCREENING ACTIVITIES CONTINUED FOR 2022

1. Continue Health Rewards for eligible CalOptima members for BCS, CCS and COL measures.
2. Continue IVR and mailers to increase awareness and the importance of cancer screenings.
3. Publish Medi-Cal and OCC newsletter articles about the importance of resuming cancer screenings during the COVID-19 pandemic.
4. Share social media messaging (Facebook, Instagram and Twitter) to occur during BCS, CCS, and COL awareness months in 2021 and 2022.
5. Geomap ZIP codes for members due for CCS to conduct a targeted social media campaign.
6. Look at disparities based on ethnicity and SDOH to have targeted interventions based on communities with highest needs.

7. Collaborate with various health networks to promote Health Reward Programs via their own outreach campaign efforts.
8. Initiate text messaging campaigns for the BCS and CCS measures.

Section 1: Quality Improvement Program Structure

Activities in the 2021 QI Program and associated Work Plan 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, Values and Strategic Initiatives of CalOptima's Board of Directors.

Components of the QI Program and Structure

The components of the QI Program are closely aligned to meet the goal of continuously improving the quality of care for our members.

QI Program Documents

1. **Annual Evaluation** — Completed a comprehensive evaluation of the QI Program and QI Work Plan at the end of the fiscal year that assesses the performance on measures/indicators.
2. **Program Description** — Developed and implemented a robust written QI program description that focuses on improving standards of care and addressing gaps in care identified in prior year's evaluation. The organization will enhance the QI Program by including "new initiatives" in the QI Program description that will outline measurable goals and objectives that CalOptima will focus on in subsequent years.
3. **Work Plan** — Created to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year based on priorities and opportunities.
4. **Policies and Procedures** — Ensure that the organization has developed and implemented appropriate policies and procedures that are needed to provide care to members.
5. **Delegation Grid —** Describes activities delegated to the health networks.
6. **Organizational Chart** — Provides a visual presentation of the reporting structure of the QI Committee, its subcommittees and its relationship to the Board of Directors.

Reviews of QI Documents

1. CalOptima successfully completed reviews of all of the above documents with the QI committees during 2021. The documents were reviewed and approved by the CalOptima Board of Directors.
2. Feedback from the practitioners who participated in the QI committee meetings were included in program documents (i.e., Program Description, Work Plan and Annual Evaluation).

Quality Improvement Committee (QIC)

1. The QIC is the primary committee that is responsible for the QI Program and reports to the Quality Assurance Committee (QAC) of the Board. The committee also recommends policy decisions.
2. The committee provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key documents in a timely manner.
3. The committee provided oversight and direction to the QI Program, Work Plan and Evaluation in the first quarter of 2021. This gave the QI department a framework on how to start implementing the QI program in 2021. For the remainder of the year, the QI staff

updated the committee on the progress of the program through regular reports. In addition to reviewing and approving the reports, the QIC (which included participating practitioners) provided valuable insight on barriers and potential interventions. These recommendations focused on enhancing performance improvement activities directed toward clinical quality, quality of service, patient safety, as well as quality cultural and ethnic accessible services. Upon evaluation of the QI activities, the QIC recommended needed actions or improvements to the activities and ensured follow-up.

4. In 2021, the QIC reviewed and provided feedback on key clinical and other coordination of care initiatives, including member outreach, provider education and outreach, incentives, educational materials and more.
5. The committee also reviewed and approved the policies and procedures.
6. The committee reviewed and provided feedback on key reports: annual analysis of HEDIS and CAHPS; access to care; and complaints and appeals. Part of the feedback included specific actions that CalOptima could take to improve performance.
7. The committee also received quarterly reports from the CPRC, UMC, MEMX, GARS and WCM CAC. These reports were summarized and presented quarterly to the QAC.

Assessment of QI Staff and Resources

CalOptima continues to dedicate significant resources and staffing to meet the needs of the QI Program. In 2020, the QI department added staff to support changes to the DHCS requirements for Facility Site Review (FSR); however, implementation of the DHCS changes were pended due to the pandemic. In Q2 2021, staff re-implemented the FSR reviews. Staff in Potential Quality Issues (PQI) were shifted to support quality of care grievance reviews. Credentialing delegation oversight was transferred from the Audit & Oversight department to Q1 in July 2021. To support the development of the Health Equity Framework, the new position of Associate Director, Population Health Management, was created. The QI department also received support from other key departments within the organization including, but not limited to, the following:

1. Quality Analytics
2. Population Health Management
3. Behavioral Health Integration
4. Case Management
5. Member Services (including outreach and engagement)
6. Provider Relations and Contracting

Review of System Resources

CalOptima has dedicated significant resources to ensuring there are adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include HEDIS Analysts for reporting, plus extensive analytic staff support. Additional support and collaboration were provided by Provider Relations, Network Management, Grievance and Appeals, and Customer Service departments.

CalOptima also utilizes three enterprise systems for utilization and care management (GuidingCare), claims payment (Facets) as well as credentialing data management (Cactus by Symplr). Although these systems are not integrated, data from the systems are stored in a data warehouse, and resources are allocated to create robust tools utilizing Tableau to analyze and generate quality reports, gaps in care reports and other relevant reports needed to support the QI Program. There is a robust data integration flow in place that allows the organization to utilize data from different sources and

identify improvement opportunities. The team also has an adequate number of business analysts as well as an ITS department that can support the reporting needs of the organization.

CalOptima issued Requests for Proposal (RFPs) for both the utilization and care management system and credentialing data management system. In 2022, CalOptima is seeking to contract with vendors who best meet system and business needs.

Overall Assessment of Program Structure

CalOptima had adequate staffing and resources required to meet the needs of the QI Program, in addition to organizational program requirements. CalOptima will continue to evaluate the needs of the program through the Work Plan, on a quarterly basis, and add staffing and additional resources, as needed, to supplement the QI department. The organization receives adequate feedback from its community practitioners about the development and implementation of the QI initiatives and programs. CalOptima continues to have significant participation from the medical directors in the development and implementation of clinical initiatives and programs throughout the year. The medical directors and QI directors report the information to senior leadership.

Section 2: Quality of Clinical Care

Adult Wellness

Evaluation of Initiatives for Specific HEDIS[1] and MCAS[2] Measures

HEDIS MY2020 results are reported in 2021, and this evaluation of quality initiatives focuses on activities performed in 2020 and 2021.

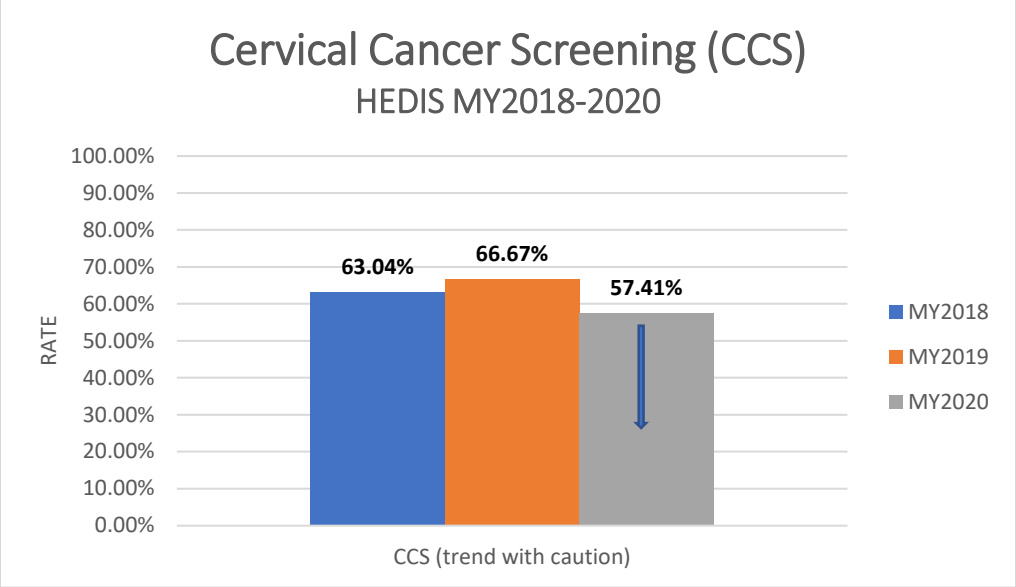
Cervical Cancer Screening (CCS): Medi-Cal

A hybrid HEDIS and MCAS measure, CCS measures the percentage of women aged 21–64 years who received one or more screening tests for cervical cancer during or within the three years prior to the measurement year or five years for women 30–64 with HPV co-testing. The figure below compares CalOptima Medi-Cal CCS rates for HEDIS MY2018, MY2019 and MY2020.

[1]HEDIS stands for Healthcare Effectiveness Data and Information Set

[2]MCAS stands for Managed Care Accountability Set, previously known as External Accountability Set (EAS)

CCS Figure 1: Trending HEDIS Rates MY2018–20 Results: Medi-Cal



NOTE: CCS Hybrid Rate Shown

CCS Table 1: CCS measure Medi-Cal Percentiles, Goal and Reporting Requirements

HEDIS Measure	QC 33rd Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements
Cervical Cancer Screening (CCS)	**57.42%**	**65.69%**	**72.68%**	**61.31%**	**HPR, MPL, P4V**

**Red is less than 33rd percentile, Green is met the goal, MPL met ++ measure triple weighted for Health Plan Ratings ↓↑ statistically higher or lower ↔ statistically no difference **HPR is health plan ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

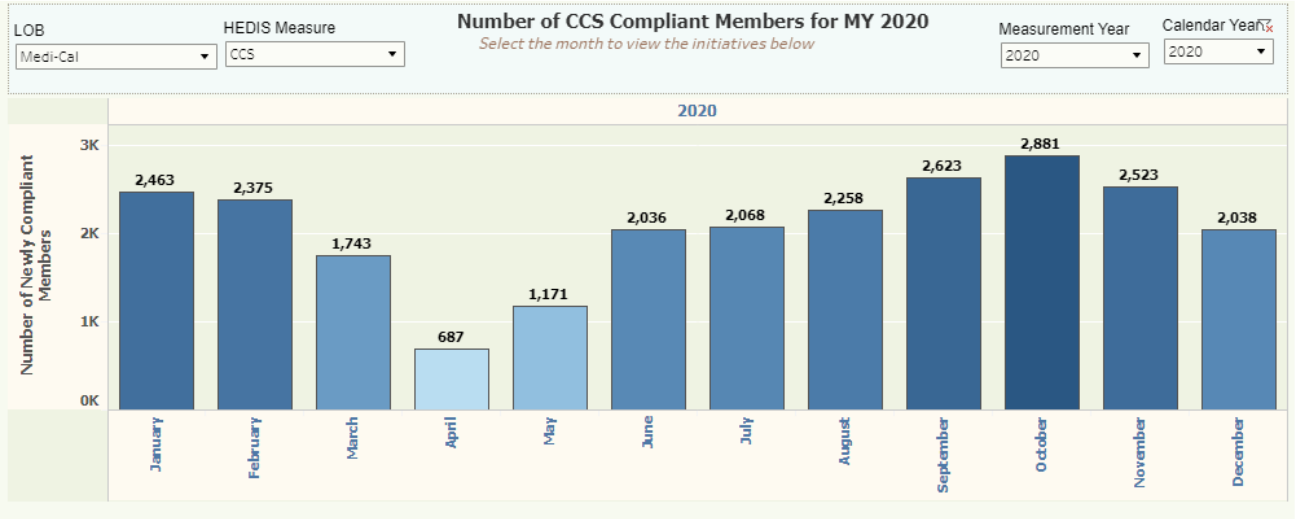
Medi-Cal

CalOptima's HEDIS MY2020 CCS rate for Medi-Cal was 57.41%. The rate decreased by 9.26 percentage points from the prior year. The CCS rates steadily increased for 2018–19, but as anticipated, there was a significant decrease in 2020 due to the COVID-19 pandemic. The measure did not meet goal of 61.31% and did not meet the MPL of 60.65%.

CCS Compliant Members for HEDIS 2020: Medi-Cal

The table below shows the number of unique members who received a cervical cancer screening month by month and the impact of interventions throughout the year.

CCS Figure 2: CCS Compliant Member for HEDIS 2020: Medi-Cal



CCS Table 2: List of MY2020 Medi-Cal CCS Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Interactive Voice Response (IVR)	2/5/2020	2/5/2020	Total Outreach: 55,529 Successful Contacts: 30,248	IVR campaign to promote Cervical Cancer Screening in Q1 2020
Member Incentive	1/1/2020	12/31/2020	Total Submission: 1165 Approved: 1043	1) $25 member incentive for completing a cervical cancer screening Other impacted measures: 1) AAP[1]
Member Mailing	9/15/2020	9/18/2020	Total: 66,362	Member incentive mailings promoting Cervical Cancer Screenings sent to eligible CalOptima members
Newsletter	7/13/2020	7/13/2020	Head of Household: 280,798	Medi-Cal Newsletter: 2020 CalOptima Health Rewards Programs
P4V	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Provider Update Newsletter	12/20/2020	12/20/2020	All health networks, including CCN providers	Provider Update about Member Health Rewards Program
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1] *Adults' Access to Preventive/Ambulatory Health Services*

Medi-Cal

The data shows the declining number of members compliant for CCS began in March 2020. The lowest number of cervical cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. This decrease in rate was followed by the increasing of cervical cancer screenings in May when preventive care screenings resumed and peaked in October 2020. Overall, the number of newly completed cervical cancer screenings month by month in 2020 was lower than the previous 2019 year except for November 2020.

CCS Table 3: Medi-Cal HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	White	Vietna-mese	No response	Other	Korean	Black	Filipino	Asian or Pacific Islander	Chinese
Numerator	28,964	14,712	15,437	10,755	2,346	1,429	1,387	1,201	903	805
Denominator	47,765	28,251	23,332	18,576	5,407	3,389	2,525	2,234	1,845	1,729
Rate	60.64%	52.08%	66.16%	57.90%	43.39%	42.17%	54.93%	53.76%	48.94%	46.56%

CCS Table 4: Medi-Cal HEDIS MY2020 Rates by Threshold Language

Admin	Language						
HEDIS MY2020	English	Spanish	Vietnamese	Korean	Farsi	Arabic	Chinese
Numerator	48,268	14,711	12,983	830	1,131	636	120
Denominator	89,283	23,238	18,851	1,909	1,757	1,173	231
Rate	54.06%	63.31%	68.87%	43.48%	64.37%	54.22%	51.95%

Note: Based on member written language preference

Medi-Cal

Table 3 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. Race/Ethnicity rates that fell below MPL of 60.65% for White, Korean, Black, Filipino, Asian or Pacific Islander, and Chinese. The lowest rate was for Korean members (42.17%) followed by members who identified as Other (43.39%). Vietnamese members have the highest rates at 66.16% followed by Hispanic members 60.64%.

Table 4 examines rates by member written language. The highest rate is for Vietnamese (68.87%) and the lowest rate is for Korean (43.48%).

2020 CCS Initiatives: Medi-Cal

1. **CCS Member Health Reward 1/1/2020–12/31/2020**
   - **A. Intervention**

     CalOptima offered a $25 gift card to eligible Medi-Cal members ages 21–64 who completed a cervical cancer screening between January to December 2020. The 2020 CCS member health reward was promoted through:

     1. IVR Outreach Call Campaign: 55,529
     2. CalOptima Website
     3. Member Newsletter Article
        1. Better Together. Medi-Cal Summer 2020: 280,798 households
     4. Member Mailing Campaign: 66,362
     5. Provider Update Newsletter

   - **B. Findings**

     The CCS health reward mailing originally scheduled for March 2020 was delayed and mailed in September 2020 to 66,362 eligible members who were due for CCS. To address health network concerns about urging preventive screening, a COVID-19 disclaimer was added to all mailings

encouraging members to discuss any risks with their doctors and to determine the best care plan weighing the risks against the benefits.

CCS Table 3: 2020 Cervical Cancer Screening Health Reward Member Mailing Campaign

CCS Health Reward Year	Forms Mailed*	Forms Received*	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
2020	66,362	1,165	1,032	137,772	0.75%

NOTE: The HEDIS denominator was used to calculate the participation rate.
**Kaiser members were excluded from member mailing campaign and member health reward*

C. Analysis

Medi-Cal

In September 2020, of the 66,362 members who were mailed the health reward form, 60,127 members remained in the denominator for the HEDIS MY2020 CCS measure. 3,678 members completed a CCS screening after the mail drop date with a rate of 2.67% (3,678/137,772). Of the 1,165 CCS health reward form submissions, 1,032 CCS health reward form submissions remained in the CCS measure denominator. The health reward participation rate for the HEDIS MY2020 CCS measure was 0.75% (1,032/137,772).

D. Barriers

1. Members may opt not to complete cervical cancer screening because of lack of general knowledge about the test itself or the physical or psychological discomfort associated with the screening.
2. Members may also have a fear about the test results and avoid getting screened.
3. Members may not be aware of the frequency of screening especially after having a previous screening with a negative result. Approximately 25% of members that were noncompliant in 2020 had a history of previously completing a cervical cancer screening.
4. Although cervical cancer screenings for Vietnamese members were the highest rate at 66.16%, other Asian subgroups have some of the lowest screening rates. There may be cultural nuances contributing to the lower screening rates for other Asian subgroups.
5. The CCS health reward mailing was originally scheduled for March 2020, yet it was delayed and mailed in September 2020 to all eligible members due to delays based on risks in members visiting providers during the height of the COVID-19 pandemic.
6. The direct mailing to members tends to be past the mid-year mark due to the HEDIS eligible population data not becoming available until the end of Q1 every year. Additionally, it is unknown which percentage of mail is returned due to wrong addresses.
7. The member health reward form requires a signed/stamped attestation by the primary care provider (PCP). This may prevent some members from participating in the CCS health reward.
8. The CCS health reward was not communicated to members or providers due to resource and budget limitations based on the pandemic and the constraints it created, which resulted in low participation.
9. Due to many factors related to the COVID-19 pandemic, such as quarantine, office closures, restrictions and general fear, preventive screenings like CCS were delayed or not completed, which may have affected member submissions of the health reward forms.

E. Opportunities for Improvement

1. Considering the current priority of the CCS measure, as HEDIS 2020 results showed the measure not meeting the minimum performance level, CCS has escalated to high priority for quality initiatives and member engagement.
2. Messaging can be more targeted for members previously compliant and provide health education on frequency of screening.
3. Develop health education material on cervical cancer screening that is culturally appropriate to race/ethnicity groups that were below MPL such as Korean, Black, Filipino, Asian or Pacific Islander, and Chinese.
4. Target higher risk members with health iniquities caused by age or race. For the Medi-Cal population, when looking at race/ethnicity, White members have the lowest rate of screening when compared to other race/ethnicity groups. In addition, we see that women ages 30–49 are less likely to be compliant than women ages 21–29 and women ages to 50–64.
5. Continue the CCS health reward through 2021 and 2022 to allow more time for members to be aware of it.
6. Conduct member reminders and enhance participation in the CCS member health reward by using multiple modes of communication, including via website, direct mailings, IVR campaigns, social medial targeted campaign and mobile text messaging.
7. Promote the CCS health reward among providers to increase participation in the program and motivate members to schedule and complete their cervical cancer screening. Have more direct collaboration with CCN providers and health network quality teams.
8. Due to new barriers experienced by COVID-19 in 2020, CalOptima will retain CCS on the 2021 and 2022 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communications.

2. CCS Interactive Voice Response (IVR) Outreach 2/5/2020

A. Intervention

CalOptima Medi-Cal members ages 21–64 who were noncompliant for CCS received a prerecorded message with two purposes: 1) encourage them to complete a CCS screening and 2) increase awareness about the available member health reward.

B. Findings

This table shows the results of noncompliant members who were targeted for the CCS IVR call campaign.

CCS Table 4: Cervical Cancer Screening IVR Outreach

2020 CCS IVR Outreach	Successful IVR Calls	Unsuccessful IVR Calls	Total IVR Calls	HEDIS MY2020 Denominator	Rate of Successful IVR Calls
CCS IVR Call Campaign	30,248	25,281	55,529	--	54.47%
HEDIS MY2020 CCS Measure	23,376	14,828	38,204	136,442	17.13%

C. Analysis

Medi-Cal

IVR prerecorded messages were in English, Spanish and Vietnamese. A successful IVR call was defined as prerecorded message was played to a live voice or prerecorded message left on voicemail. Of the 55,529 total IVR calls made, 30,248 of the calls were successfully completed, a rate of 54.47% (3,0248/55,529). Of the 55,529 members targeted, 38,204 were in the denominator for the HEDIS MY2020 CCS measure. The rate of successful IVR calls for the HEDIS MY2020 CCS measure was 17.13% (23,376/136,442).

D. Barriers

1. Unsuccessful IVR call outcomes were largely due to the members hanging up before listening to full prerecorded message, no answer/busy and bad number. Bad numbers accounted for 7.63% of the total IVR calls made.
2. IVR call campaigns were put on hold due to COVID-19 pandemic and Telephone Consumer Protection Act (TCPA) concerns.

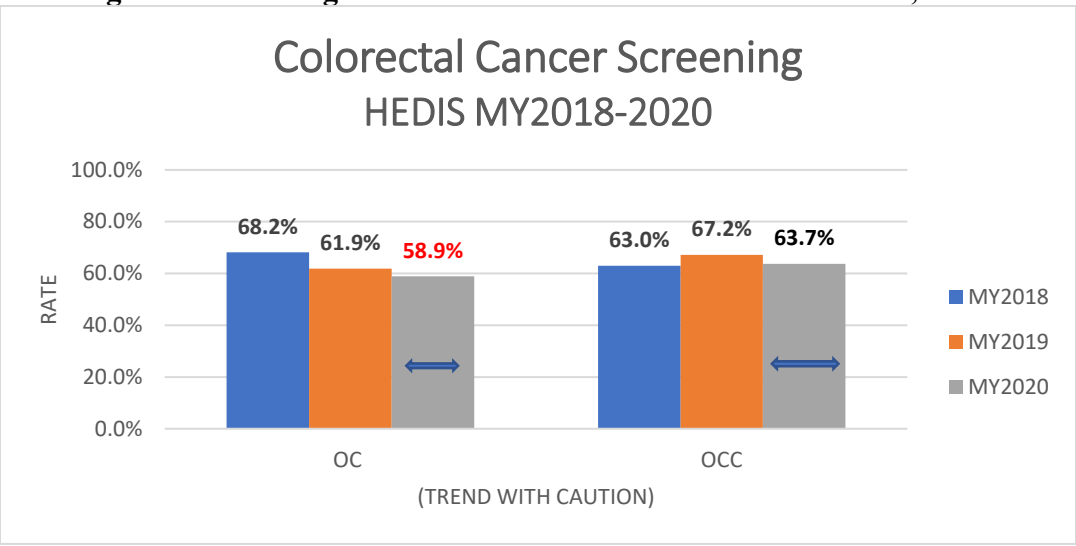
E. Opportunities for Improvement

1. Expand member outreach modality beyond CCS IVR call campaign as the only method to notify members when they are due for CCS.
2. Continue CCS IVR call campaign as part of a more robust member communication/touchpoint plan.
3. Redesign CCS IVR call campaign to be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race.
4. Make use of mobile text messaging and IVR campaigns in 2022.

Colorectal Cancer Screening (COL): OneCare, OneCare Connect

The hybrid HEDIS measure, COL, measures the percentage of members 50–75 years of age who had appropriate screening for colorectal cancer, which includes either Fecal Occult Blood Test (FOBT) during the measurement year, a flexible sigmoidoscopy during the past 5 years or a colonoscopy within the past 10 years. The table below compares CalOptima COL rates for HEDIS MY2018, MY2019 and MY2020 by line of business.

COL Figure 1: Trending HEDIS Rates MY2018–2020 Results: OC, OCC



COL Table 1: COL Measure OC and OCC Star Rating, Goal and Reporting Requirements

HEDIS Measure: COL	Projected 3-Star**	Projected 4-star**	Projected 5-star**	Goal	Reporting Requirements
OC	62%	73%	80%	73%	Star
OCC	62%	73%	80%	73%	Star, P4V

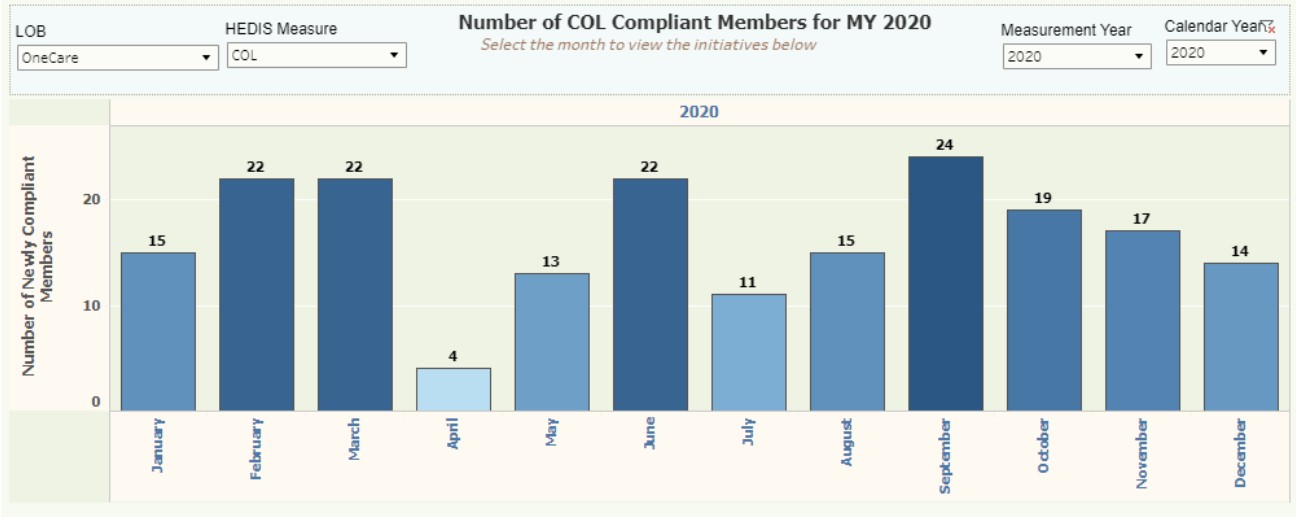
**Red is less than 3-Star or 50th percentile, Green is met the goal **Star cut points are previous year*
↓↑ statistically higher or lower ↔ statistically no difference

OneCare
CalOptima's HEDIS MY2020 COL rate for OneCare was 58.9%. The rate decreased by 3 percentage points from the prior year. The rates have decreased for COL from 2018–2020 with no significant difference between 2019 and 2020. As anticipated, there was further decline in the 2020 rate due to the COVID-19 pandemic, and CalOptima did not meet goal of 73%. As a result, CalOptima's Star rating is 2.

OneCare Connect
CalOptima's HEDIS MY2020 COL rate for OneCare Connect was 63.7%. The rate decreased by 3.5 percentage points from the prior year. The rates for COL have gradually increased from 2018–2019 with no significant difference between 2019 and 2020. However, as anticipated there was decline in the 2020 rate due to the COVID-19 pandemic. As a result, CalOptima's Star rating is 3.

COL Compliant Members for HEDIS 2020: OC, OCC
Figure 2 below shows the number of unique members who received a COL month by month and the impact of interventions throughout the year for OC and OCC.

COL Figure 2: COL Compliant Members for HEDIS 2020: OC

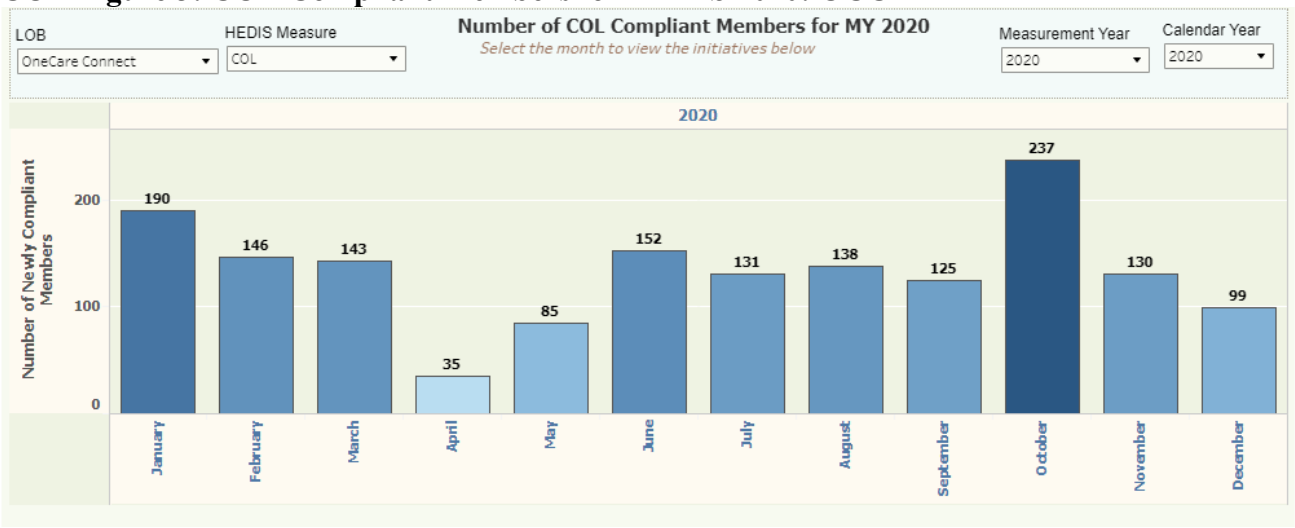


OneCare
The data shows the lowest number of colorectal cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Screenings increased in May, as preventive care resumed, and decreased again in July 2020 and peaked in September 2020.

COL Table 2: List of MY2020 OneCare COL Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 0	1) $50 member incentive for completing a sigmoidoscopy or colonoscopy
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

COL Figure 3: COL Compliant Members for HEDIS 2020: OCC



OneCare Connect

The data shows the declining number of members compliant for COL began in March 2020. The lowest number of colorectal cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Screenings increased in May as preventive care resumed and peaked in October 2020.

COL Table 3: List of MY2020 OneCare Connect COL Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 30 Approved: 21	1) $50 member incentive for completing a sigmoidoscopy or colonoscopy
Newsletter	4/17/2020	4/17/2020	HOH[1]: 14,217	OCC Newsletter: 2020 CalOptima Health Rewards Programs
Newsletter	8/6/2020	8/6/2020	HOH[1]: 14,501	OCC Newsletter: No-Cost Colorectal Cancer Screening for People 50 and Older/2020 CalOptima Heath Reward Program
P4V	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1]*HOH = Head of Household*

OneCare Connect
The data shows the declining number of members compliant for COL began in March 2020. The lowest number of colorectal cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Screenings increased in May as preventive care resumed and peaked in October 2020.

COL Table 4: OneCare HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	White	Hispanic	No response	Vietna-mese	Other	Filipino	Asian or Pacific Islander	Black	Chinese	Korean
Numerator	166	112	37	35	18	4	7	4	7	5
Denominator	343	220	97	62	41	16	13	11	11	7
Rate	48.40%	50.91%	38.14%	56.45%	43.90%	25.00%	53.85%	36.36%	63.64%	71.43%

COL Table 5: OneCare HEDIS MY2020 Rates by Threshold Language

Admin	Language					
HEDIS MY2020	English	Spanish	Vietnamese	Korean	Farsi	Arabic
Numerator	265	91	40	3	2	1
Denominator	607	165	57	4	2	1
Rate	43.66%	55.15%	70.18%	75.00%	100.00%	100.00%

Note: Based on member written language preference

OneCare
Table 4 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. The race/ethnicity groups that fell below a 3 Star rating of 62% are White, Hispanic, Vietnamese, Filipino, Asian or Pacific Islander, and Black members. The lowest rate is for Black members (36.36%) but the group has a low denominator count. The lowest rate with substantial members is for White members (48.40%). Korean members have the highest rate at 71.43% followed by Chinese members 63.64% but both groups have a low denominator count. The highest rate with substantial members is Hispanic members (50.91%). Table 5 examines rates by member written language the highest rate with substantial member count is Vietnamese (70.18%) and the lowest rate is for English members (43.66%).

COL Table 6: OneCareConnect HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	White	No response	Vietna-mese	Other	Asian or Pacific Islander	Black	Filipino	Unknown	Chinese
Numerator	996	712	536	308	196	153	62	73	51	28
Denominator	1,746	1,489	1,144	607	367	330	129	112	83	53
Rate	57.04%	47.82%	46.85%	50.74%	53.41%	46.36%	48.06%	65.18%	61.45%	52.83%

COL Table 7: OneCareConnect HEDIS MY2020 Rates by Threshold Language

Admin	Language						
HEDIS MY 2020	English	Spanish	Vietnamese	Farsi	Arabic	Korean	Chinese
Numerator	1551	1019	520	57	27	12	0
Denominator	3225	1762	1050	87	40	19	1
Rate	48.09%	57.83%	49.52%	65.52%	67.50%	63.16%	0.00%

Note: Based on member written language preference

OneCare Connect

Table 6 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. All race/ethnicity rates, except Filipino, fell below a 3-star rating of 62%. The lowest rate was for Asian or Pacific Islander (48.06%) followed by members that did not provide race/ethnicity information (46.85%). Filipino members have highest rate of 65.18%. Table 7 examines rates by member written language, with the highest rate for Arabic (67.50%) and the lowest rate for English (48.09%).

2020 COL Initiatives: OneCare, OneCare Connect

1. COL Member Health Reward 1/1/2020–12/31/2020

A. Intervention

CalOptima offered a $50 gift card to eligible CalOptima OneCare and OneCare Connect members ages 50–75 who completed a sigmoidoscopy or colonoscopy between January to December 2020. The 2020 COL member health reward was promoted through:

1. CalOptima website
2. Member newsletter article (OCC only)
    a. OneCare Connections Spring 2020. Head of Household (HOH) 14,217
    b. OneCare Connections Summer 2020. HOH 14,501

B. Findings

The table below shows the results of COL health reward form submissions for 2020.

COL Table 4: 2020 Colorectal Cancer Screening Health Reward

COL LOB	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Health Reward Participation Rate
OneCare	0	0	836	0%
OneCare Connect	30	12	6,184	0.19%

NOTE: The HEDIS denominator was used to calculate the participation rate.
**Kaiser members were excluded from member health reward.*

C. Analysis

OC

The health reward participation rate for the HEDIS 2020 COL was 0%.

OCC

In 2020, of the 30 COL health reward form submissions, 12 COL health reward form submissions remained in the COL measure denominator. The health reward participation rate for the HEDIS 2020 COL was 0.19%.

D. Barriers

1. Members may not complete their colorectal cancer screening because of the discomfort associated with the procedure and/or fear about learning of the test results.
2. Members are not aware of the multiple screening options that are available to them and the frequency of screening for each option.
3. There was no COL health reward mailing scheduled in 2020 due to resource and budget constraints.
4. The member health reward form requires a signed/stamped attestation by the PCP. This may prevent some members from participating in the program.
5. The member health reward was not communicated effectively to members or providers resulting in low member participation.
6. Due to the COVID-19 pandemic, there was a drop in colorectal cancer screenings starting in April 2020. CalOptima's rate report continues to show a decline when compared with the same time the prior year.

E. Opportunity for Improvement

1. The messaging can be more targeted for members who were previously compliant. In the messaging, CalOptima will include information about the screening options and frequency.
2. CalOptima will target higher risk members due to health iniquities caused by age or ethnicity. For OC and OCC population, when examining ethnicity, White members have the lowest rate of screening when compared with other ethnic groups. In addition, we see members ages 65–75 are less likely to be compliant than members 50–64 years of age.
3. CalOptima will continue the COL member health reward through 2021 and 2022 to allow more time for members to be aware of the health reward offered.
4. Participation in the COL member health reward can be enhanced by using multiple modes of communication via website, direct mailings, IVR campaigns, social media targeted campaigns and mobile text messaging. Improve direct collaboration with CCN

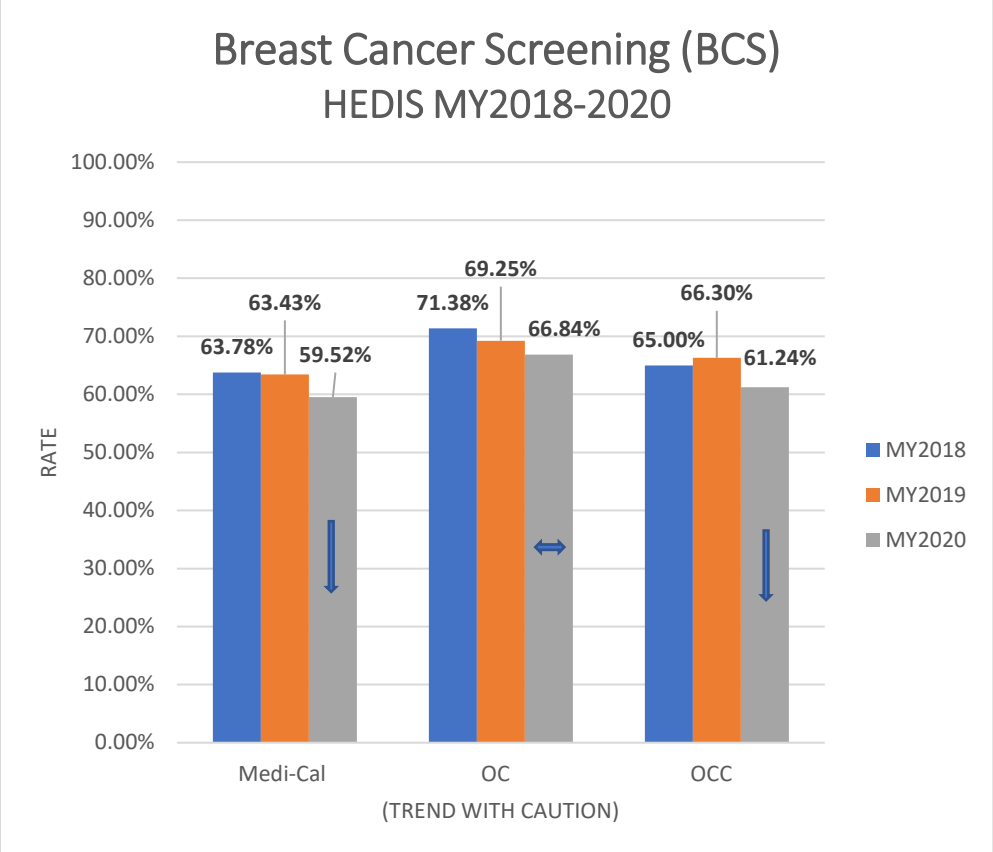
providers and health network quality teams. CalOptima plans to use more strategic member engagement strategies with external vendors.

5. Due to new barriers experienced from COVID-19 in 2020, CalOptima will retain COL on the 2021 and 2022 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communications.

Breast Cancer Screening (BCS): Medi-Cal, OneCare, OneCare Connect

The administrative HEDIS and MCAS measure, BCS, measures the percentage of members who are women in the age range of 50–74 years old, and have received one or more mammograms on or between October 1 two years prior to the measurement year and December 31 of the measurement year. The figure below compares CalOptima BCS rates for HEDIS MY2018, MY2019 and MY2020 by line of business.

BCS Figure 1: Trending HEDIS Rates MY2018–2020 Results: Medi-Cal, OC, OCC



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BCS Table 1: BCS Measure Medi-Cal Percentiles, Goal and Reporting Requirements

HEDIS Measure: BCS Medi-Cal	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Medi-Cal	**55.08%**	**61.84%**	**69.22%**	**58.82%**	HPR, **MPL**, P4V

**Red is less than 33rd percentile, Green is met the goal, MPL met ++ measure triple weighted for Health Plan Ratings ↓↑ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value*

BCS Table 2: BCS Measure OneCare and OneCare Connect Star rating, Goal and Reporting Requirements

HEDIS Measure: BCS	Projected 3-Star**	Projected 4-star**	Projected 5-star**	Goal	Reporting Requirements**
OneCare	66%	76%	83%	76%	Star
OneCare Connect	66%	76%	83%	76%	Star, P4V

**Red is less than 3-Star or 50th percentile, Green is met the goal **Star cut points are previous year ↓↑ statistically higher or lower ↔ statistically no difference, P4V=Pay for Value*

Medi-Cal

CalOptima's HEDIS MY2020 BCS rate for Medi-Cal was 59.52%. The rate decreased by 3.91 percentage points from the prior year. The rates have been steady for BCS for 2018–19 but, as anticipated, there was a significant decrease in the 2020 rate due to the impact of the COVID-19 pandemic. Regardless of the decrease, CalOptima did meet the goal of 58.82%. The rate exceeded the minimum performance level of 58.67%.

OneCare

CalOptima's HEDIS MY2020 BCS rate for OneCare was 66.84%. The rate decreased by 2.41 percentage points from the prior year. The rates have decreased for BCS from 2018–20, but there was no significant difference between 2019 to 2020. As anticipated, the decline in the 2020 rate is attributed to the COVID-19 pandemic, and the measure did not meet the goal of 76%. As a result, the Star rating is a 3.

OneCare Connect

CalOptima's HEDIS MY2020 BCS rate for OneCare Connect was 61.24%. The rate decreased by 5.06 percentage points from the prior year. The rates for BCS have gradually increased from 2018–2019 however, as anticipated, a significant decline occurred in the 2020 rate due to the COVID-19 pandemic, but did not meet goal of 76%. As a result, the Star rating is 2.

BCS Compliant Members for HEDIS MY2020: Medi-Cal, OC, OCC

Figure 2 below shows the number of unique members who received a BCS mammogram month by month and the impact of interventions throughout the year for Medi-Cal, OC and OCC.

BCS Figure 2: BCS Compliant Member for HEDIS MY2020: Medi-Cal

BCS Table 3: List of MY2020 Medi-Cal BCS Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 681 Approved: 633	1) $25 member incentive for completing a screening mammogram Other impacted measures: 1) AAP[1]
Member Mailing	9/18/2020	9/21/2020	Total: 17,862	Member incentive mailings promoting Breast Cancer Screenings sent to eligible CalOptima members
Newsletter	7/13/2020	7/13/2020	HOH: 280,798	Medi-Cal Newsletter: 2020 CalOptima Health Rewards Programs
P4V	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Provider Update Newsletter	12/20/2020	12/20/2020	All health networks and CCN providers	Provider Fax Blast (Provider Update): CalOptima 2021 Member Health Rewards Program
Social Media Posting 1	10/20/2020	10/20/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Social Media Posting 2	10/6/2020	10/7/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1] *Adults' Access to Preventive/Ambulatory Health Services*

Medi-Cal

The data shows the declining number of members compliant for BCS began in March 2020. The lowest number of breast cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Breast cancer screenings began increasing in May, as preventive care screenings resumed, and peaked in October 2020. Overall, the number of newly completed breast cancer screenings month by month in 2020 was lower than the previous 2019 year except for February 2020, August 2020 and November 2020.

BCS Figure 3: BCS Compliant Member for HEDIS MY2020: OC

BCS Table 4: List of MY2020 OneCare BCS Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 3 Approved: 2	1) $25 member incentive for completing a screening mammogram Other impacted measures: 1) AAP[1]
Member Mailing	9/18/2020	9/21/2020	Total: 74	Member incentive mailings promoting Breast Cancer Screenings sent to eligible CalOptima members
Social Media Posting 1	10/20/2020	10/20/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Social Media Posting 2	10/6/2020	10/7/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1] *Adults' Access to Preventive/Ambulatory Health Services*

OneCare

The data shows the declining number of members compliant for BCS began in March 2020. The lowest number of breast cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Breast cancer screenings began increasing in May, as preventive care screenings resumed, and peaked in October 2020.

BCS Figure 4: BCS Compliant Member for HEDIS MY2020: OCC

BCS Table 5: List of MY2020 OneCare Connect BCS Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 72 Approved: 62	1) $25 member incentive for completing a screening mammogram Other impacted measures: 1) AAP[1]
Member Mailing	9/18/2020	9/21/2020	Total: 1,411	Member incentive mailings promoting Breast Cancer Screenings sent to eligible CalOptima members
Newsletter	4/17/2020	4/17/2020	HOH: 14,217	OCC Newsletter: 2020 CalOptima Health Rewards Programs
Newsletter	8/6/2020	8/6/2020	HOH: 14,501	OCC Newsletter: 2020 CalOptima Health Rewards Programs
P4V	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Social Media Posting 1	10/20/2020	10/20/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Social Media Posting 2	10/6/2020	10/7/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1]*Adults' Access to Preventive/Ambulatory Health Services*

OneCare Connect

The data shows the declining number of members compliant for BCS began in March 2020. The lowest number of breast cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Breast cancer screenings began increasing in May, as preventive care screenings resumed, and peaked in October 2020.

Race/Ethnicity and Language Analysis: Medi-Cal, OneCare and OneCare Connect

BCS Table 6: Medi-Cal HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	Viet-namese	White	No response	Other	Korean	Asian or Pacific Islander	Filipino	Chinese	Black
Numerator	6,816	6,492	3,725	2,864	707	642	452	442	330	287
Denominator	10,923	9,416	7,734	4,818	1,382	1,121	815	755	661	542
Rate	62.40%	68.95%	48.16%	59.44%	51.16%	57.27%	55.46%	58.54%	49.92%	52.95%

BCS Table 7: Medi-Cal HEDIS MY2020 Rates by Threshold Language

Admin	Language						
HEDIS MY2020	English	Vietnamese	Spanish	Korean	Farsi	Arabic	Chinese
Numerator	8252	6083	5464	534	540	241	64
Denominator	16298	8748	8478	893	792	388	119
Rate	50.63%	69.54%	64.45%	59.80%	68.18%	62.11%	53.78%

Note: Based on written member language preference

Medi-Cal

Tables 6 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. Race/ethnicity rates that fell below MPL of 58.67% were White, Korean, Asian or Pacific Islander, Chinese and Black members. The lowest rate is for White members (48.16%) followed by Chinese members (49.92%). Vietnamese members have the highest rates (68.95%) followed by Hispanic members (62.40%). Table 7 examines rates by member written language, with the highest rate for Vietnamese (69.54%) and the lowest rate for English (50.63%).

BCS Table 8: OneCare HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	White	Hispanic	No response	Vietna-mese	Other	Filipino	Asian or Pacific Islander	Black	Chinese	Korean
Numerator	182	147	72	44	24	12	12	10	4	2
Denominator	297	225	94	64	29	14	12	12	8	6
Rate	61.28%	65.33%	76.60%	68.75%	82.76%	85.71%	100.00%	83.33%	50.00%	33.33%

BCS Table 9: OneCare HEDIS MY2020 Rates by Threshold Language

Admin	Languages				
HEDIS MY2020	English	Spanish	Vietnamese	Korean	Farsi
Numerator	183	56	21	1	1
Denominator	271	87	31	2	1
Rate	67.53%	64.37%	67.74%	50.00%	100.00%

Note: Based on written member language preference

OneCare

Table 8 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. Race/ethnicity rates that fell below 3-Star rating of 66% are for White, Hispanic, Chinese and Korean members. The lowest rate is for Korean members (33.33%) followed by Chinese members (50.00%), but these race/ethnicities have a low denominator count. The lowest rate with substantial membership is for White members (61.28%). Members who did not provide race/ethnicity information has highest rates (76.60%) followed by Vietnamese members (68.75%). Table 9 examines rates by member written language, with the highest rate for Vietnamese (67.74%) and the lowest rate for Korean (50%), but the group has a low denominator count.

BCS Table 10: OneCare Connect HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	White	No response	Vietna-mese	Other	Asian or Pacific Islander	Black	Filipino	Unknown	Chinese
Numerator	1,175	728	694	360	208	182	80	82	62	34
Denominator	1,725	1,420	1,160	546	348	322	124	106	90	48
Rate	68.12%	51.27%	59.83%	65.93%	59.77%	56.52%	64.52%	77.36%	68.89%	70.83%

BCS Table 11: OneCare Connect HEDIS MY2020 Rates by Threshold Language

Admin	Languages					
HEDIS MY2020	English	Spanish	Vietnamese	Farsi	Arabic	Korean
Numerator	846	648	304	25	9	7
Denominator	1535	903	494	43	17	11
Rate	55.11%	71.76%	61.54%	58.14%	52.94%	63.64%

Note: Based on written member language preference

OneCare Connect

Table 10 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. Race/ethnicity rates that fell below 3-Star rating of 66% are for White, Vietnamese, Asian or Pacific Islander and Black members. The lowest rate is for White members (51.27%) followed by Asian or Pacific Islander (56.52%). Filipino members have the highest rates (77.36%) followed by Chinese members (70.83%). Table 11 examines rates by member written language, with the highest rate for Spanish (71.76%) and the lowest rate for Arabic (52.94%), but the group has a low denominator count.

2020 BCS Initiatives: Medi-Cal, OneCare, OneCare Connect

1. **BCS Member Health Reward 1/1/2020–12/31/2020**
   - **A. Interventions**

     CalOptima offered a $25 gift card to eligible CalOptima members ages 50–74 who completed a breast cancer screening mammogram between January to December 2020. The 2020 BCS member health reward program was promoted through:

     1. CalOptima website
     2. Member newsletter article
        a. Better. Together. Medi-Cal Summer 2020. HOH 280,798
        b. OneCare Connections. OneCare Connect Spring 2020. HOH 14,217
        c. One Care Connections. OneCare Connect Summer 2020. HOH 14,501

3. Member mailing campaign: Medi-Cal: 17,862; OC: 74; OCC: 1,411

B. Findings

The BCS health reward mailing originally scheduled for March 2020 was delayed and mailed in September 2020 to all eligible members who were due for BCS. To address health network concerns about urging preventive screening, a COVID-19 disclaimer was added to all mailings encouraging members to discuss any risks with their doctors and to determine the best care plan weighing the risks against the benefits.

BCS Table 6: 2020 Breast Cancer Screening Health Reward Member Mailing Campaign

BCS LOB	Forms Mailed*	Forms Received*	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
Medi-Cal	17,862	681	471	39,110	1.20%
OneCare	74	3	0	392	0.00%
OneCare Connect	1,411	72	40	3,003	1.33%

NOTE: The HEDIS denominator was used to calculate the participation rate.
**Kaiser members were excluded from member mailing campaign and member health reward.*

C. Analysis

Medi-Cal

In 2020, of the 17,862 members who were mailed the health reward form in September 2020, 16,517 remained in the denominator for the HEDIS 2020 BCS measure. Of those, 1,234 members completed a BCS after the mail drop date with a rate of 3.46% (1,234/35,716). Of the 681 BCS health reward form submissions, 471 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS 2020 BCS measure was 1.32% (471/35,716).

OneCare

In 2020, of the 74 members who were mailed the health reward form in September 2020, 51 remained in the denominator for the HEDIS 2020 BCS measure. Of those, 3 members completed a BCS after the mail drop date with a rate of 0.77% (3/392). Of the 3 BCS health reward form submissions, 0 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS 2020 BCS was 0%.

OneCare Connect

In 2020, of the 1,411 members who were mailed the health reward form in September 2020, 1,264 remained in the denominator for the HEDIS 2020 BCS measure. Of those, 89 members completed a BCS after the mail drop date with a rate of 2.96% (89/3,003). Of the 89 BCS health reward form submissions, 40 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS 2020 BCS was 1.33%.

D. Barriers

1. Members may not complete their mammography screening because of the discomfort associated with the procedure and/or are afraid to know the result.

2. Members may not be aware of the frequency of screening especially after having a previous screening with a negative result. Approximately 40% of members who were noncompliant in 2020 had a history of previously completing a mammogram.
3. The BCS health reward mailing originally scheduled for March 2020 was delayed and mailed in September 2020 to all eligible members who were due for BCS.
4. The direct mailing to member tends to be past the mid-year mark due to the HEDIS eligible population not becoming available until the end of Q1 every year. Additionally, it is unknown what percentage of mail is returned due to wrong addresses.
5. The member health reward form requires a signed/stamped attestation by the PCP or imaging center, which may prevent some members from participating in the BCS health reward.
6. Health reward was not communicated to members or providers due to resource and budget limitations caused by the COVID-19 pandemic, which resulted in low participation. For instance, 10,903 Medi-Cal members completed their mammogram screening in 2020 but only 463 submitted their health reward form.
7. Due to many factors related to the COVID-19 pandemic such as quarantine, office closures, restrictions and general fear, there was a drop in breast cancer screening starting in March 2020. CalOptima's 2021 rate reports continue to show a decline when compared with the same time last year.

E. Opportunity for Improvement

1. Messaging can be more targeted for members previously compliant and provide health education on the frequency of screening.
2. Target our higher risk members due to health iniquities caused by age or race. For the Medi-Cal population, White members have the lowest rate of screening when compared with other race/ethnicity groups. In addition, women ages 56–64 are less likely to be compliant than women 65–75 years of age.
3. Continue the BCS health reward through 2021 and 2022 to allow more time for members to be aware of the health reward offered.
4. Conduct member reminders and enhance participation in the BCS member health reward by using multiple modes of communication via website, direct mailings, IVR campaigns, social media targeted campaign and mobile text messaging. CalOptima plans to use more strategic member engagement strategies.
5. Promote the BCS health reward among providers and radiology centers to increase participation in the program. Improve more direct collaboration with CCN providers and health network quality teams.
6. Due to new barriers experienced by COVID-19 in 2020, CalOptima will retain BCS on the 2021 and 2022 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communications.

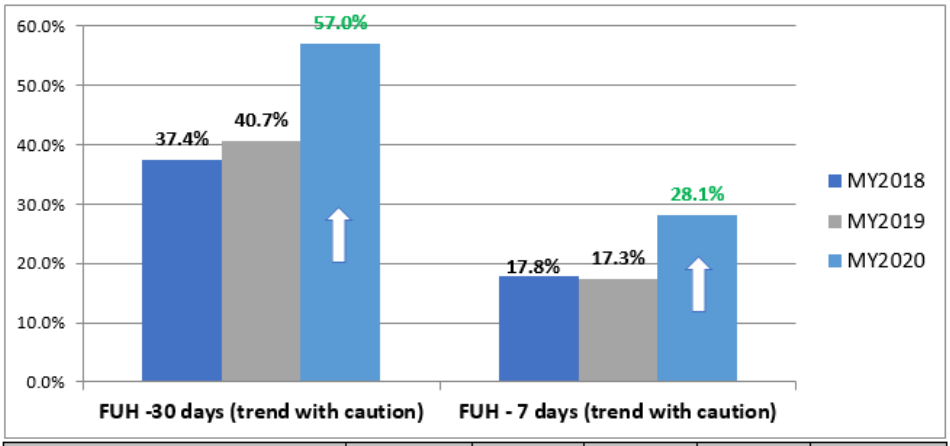
Behavioral Health Quality Initiatives

Follow-Up After Hospitalization for Mental illness Within 7 and 30 Days of Discharge (FUH)

A. Interventions

1. The Transition of Care Management (TCM) team continued outreach to members post-discharge to coordinate follow-up appointments and address potential barriers (e.g., transportation). The team continued to build relationships with facilities, behavioral health (BH) providers, and county staff that further increased engagement.
2. The TCM team continued to meet weekly with the BH medical director to discuss concurrent reviews and internal coordination interventions.
3. In January 2021, CalOptima launched the Behavioral Health Integration Incentive Program (BHIIP). The DHCS incentive program allowed plan providers to apply for various projects focused on improving health outcomes, care delivery efficiency and patient experience. Two provider groups were selected for the Improving Follow-Up After Hospitalization for Mental Illness project. In June, the Behavioral Health Integration (BHI) quality team attended a learning collaborative meeting and discussion occurred surrounding successes and barriers for the providers focused on follow-up visits post discharge.
4. BHI quality team researched and reviewed other health plan strategies to improve rates and motivate members to participate in care (e.g., offering member incentives), as well as challenges (e.g., member willingness to participate in own care).

B. Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	40.16%	53.85%	71.43%	56%	Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++	20.98%	30.77%	45.62%	18.20%	CMS

*Red = less than 3-Star or 50th percentile, Green= met the goal **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference

C. Analysis

In 2020, CalOptima's HEDIS goal for OCC FUH-30 days was 56%; CalOptima exceeded this goal with a rate of 57%. The goal for FUH-7 days was set at 18.20% and CalOptima also exceeded this goal with a rate of 28.1%. We have continued to establish a significant upward trend over the past few years in both the 30-day and 7-day follow-up.

D. Barriers

1. The discharge planning procedure is not standardized among the hospitals that serve members. In addition, resistance from a specific facility has been an issue (i.e., not sharing information regarding aftercare plan or post discharge appointment). This issue

has been shared with the Provider Relations department who provided information on the importance of coordination of care post hospitalization.
2. The TCM team was not always able to contact members after they had been discharged from the hospital, particularly when the members are experiencing homelessness or did not provide the hospital with their contact information.
3. Other health plan strategies (e.g., offering member incentives) were not an option due to lack of incentive funding.

E. Opportunities for Improvement

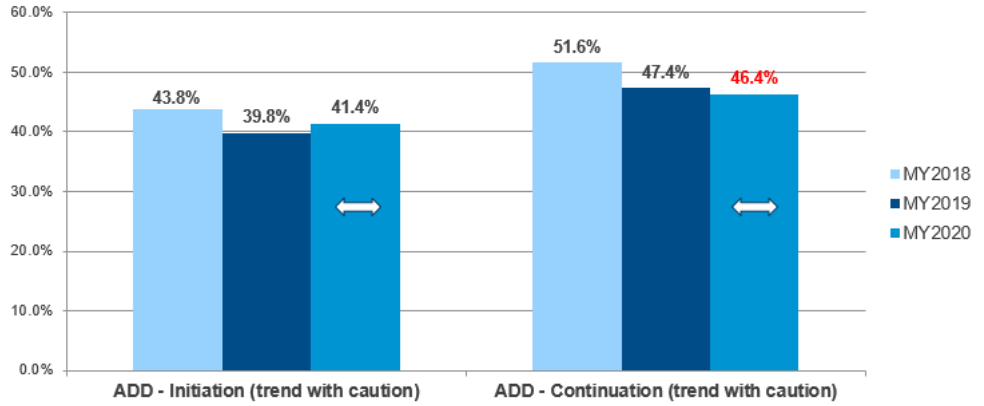
1. CalOptima can conduct more collaboration with provider groups selected for the BHIIP project to improve follow-up after hospitalization.
2. The TCM team will continue to conduct post discharge member outreach to ensure members are able to attend follow-up appointments.
3. The BHI management team can conduct additional hospital visits to educate discharge planning staff about FUH requirements and address any questions or concerns.

Follow-Up Care for Children With Prescribed ADHD Medication (ADD)

A. Interventions

1. Pharmacy-related intervention continued, placing a 30-day limit for the initial fill of Attention-Deficit Hyperactivity Disorder (ADHD) medication to encourage members to follow up with the prescriber within 30 days.
2. BHI quality team continued to track/trend providers who were noncompliant with this measure. Providers with high frequency of noncompliance were sent a letter to inform them about ADD requirements and the importance of follow-up visits with members prescribed ADHD medications.
3. BHI quality team updated prior report to track when members first filled ADHD medications and conducted member outreach to ensure a 30-day follow-up appointment had been scheduled.
4. BHI quality team created and submitted an article for the Spring edition of the CalOptima member newsletter to educate on the importance of attending follow-up visits with a provider.

B. Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	38.18%	46.53%	55.33%	42.95%	
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	48.65%	58.76%	67.98%	54.73%	HPR

*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

C. Analysis

CalOptima's 2020 HEDIS Initiation Phase final rate was 41.4%, which did not meet the intended goal of 42.95%. The 2020 HEDIS Continuation Phase final rate was 46.4%, which also did not meet the intended goal of 54.73%. The Initiation Phase has a trend that has been fluctuating the past three years. The Continuation Phase has been trending downward for the past three years.

D. Barriers

1. The provider letter was faxed to the number on record. We are aware that the fax may not always go to the intended provider to whom the letter was faxed.
2. Due to the ongoing PHE, there was limited access to appointment scheduling in a timely manner for the member.
3. Due to limited resources, reporting needs were delayed impacting provider outreach intervention targeted to improve Continuation Phase numbers as initially intended. As a result, the shift to update a prior report allowed member outreach to target Initiation Phase did not occur until later in the year.
4. Pharmacy-related intervention (i.e., 30-day limit for the initial fill of ADHD medication) will discontinue due to the new pharmacy benefit carve out (i.e., Medi-Cal Rx) beginning 1/1/2022.

E. Opportunities for Improvement

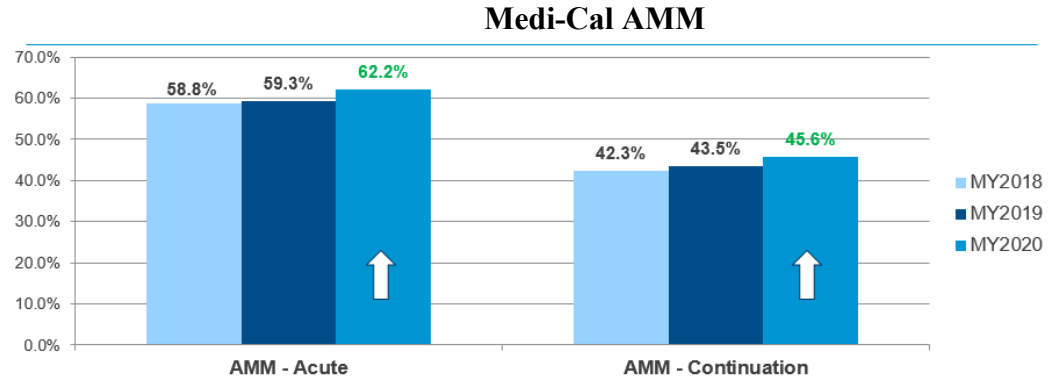
1. The BHI quality team will continue to send letters to providers who are not meeting the ADD requirements.
2. The BHI quality team will explore opportunities to continue member outreach to identify barriers and assist members with appointment scheduling if necessary.
3. ADD materials will be updated yearly and the team will distribute new materials to providers and members as part of the outreach effort.

Antidepressant Medication Management (AMM)

A. Interventions

1. The BHI quality team created a depression factsheet and posted it to the CalOptima website for virtual distribution to allow providers to share with members during telehealth visits. The factsheet included information on depression and importance of treatment compliance.
2. The BHI quality team created and distributed a provider letter on reminding members of importance of medication adherence as well as communicate standards and guidelines regarding the measure. The letter also included a link to the depression factsheet located on the CalOptima website to share with the members they serve.
3. The BHI quality team created an article, "Understanding Depression," for the Summer 2021 Medi-Cal member newsletter. The article included a section on how to manage your medicines.
4. Additional member materials were posted on social media (e.g., Facebook and Instagram).
5. BHI quality team developed HEDIS reporting tip sheet for provider education.

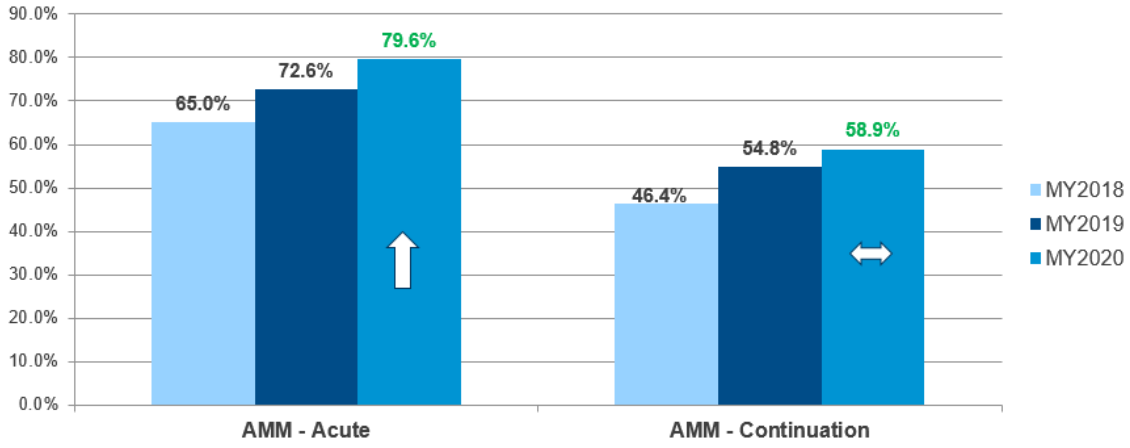
B. Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Antidepressant Medications Management (AMM) - Acute Phase Treatment	51.47%	56.85%	64.29%	61.61%	MPL, P4V
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	35.76%	41.17%	49.37%	38.18%	HPR, MPL, P4V

*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

OCC AMM



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Antidepressant Medications Management (AMM) - Acute Phase Treatment	68.93%	74.78%	83.33%	74.78%	CMS
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	52.13%	58.82%	67.07%	56.17%	CMS

*Green= met the goal **Star cut points are previous year.
↑ ↓ statistically higher or lower ↔ statistically no difference

C. Analysis

Medi-Cal AMM: CalOptima's 2020 HEDIS acute phase final rate was 62.2%, exceeding the intended goal of 61.61%. The continuation phase final rate was 45.6%, exceeding the intended goal of 38.18%. Both the acute phase and continuation phase continue to demonstrate an upward trend over the past several years.

OCC AMM: CalOptima's 2020 HEDIS acute phase final rate was 79.6%, exceeding the intended goal of 74.78%. The continuation phase final rate was 58.9%, exceeding the intended goal of 56.17%. Both the acute phase and continuation phase continue to demonstrate an upward trend over the past several years.

D. Barriers

The COVID-19 pandemic dramatically changed provider educational events. As a result, there was no opportunity to promote provider education on the AMM measure. Planning for future educational activities may be a challenge considering the unknown impact of the current health crisis.

E. Opportunities for Improvement

1. Conduct member outreach to remind members of the importance of medication adherence.
2. Continue to educate members about the importance of depression medication adherence via member newsletters and social media.
3. Continue to work with Provider Relations on identifying alternative ways of hosting educational events.

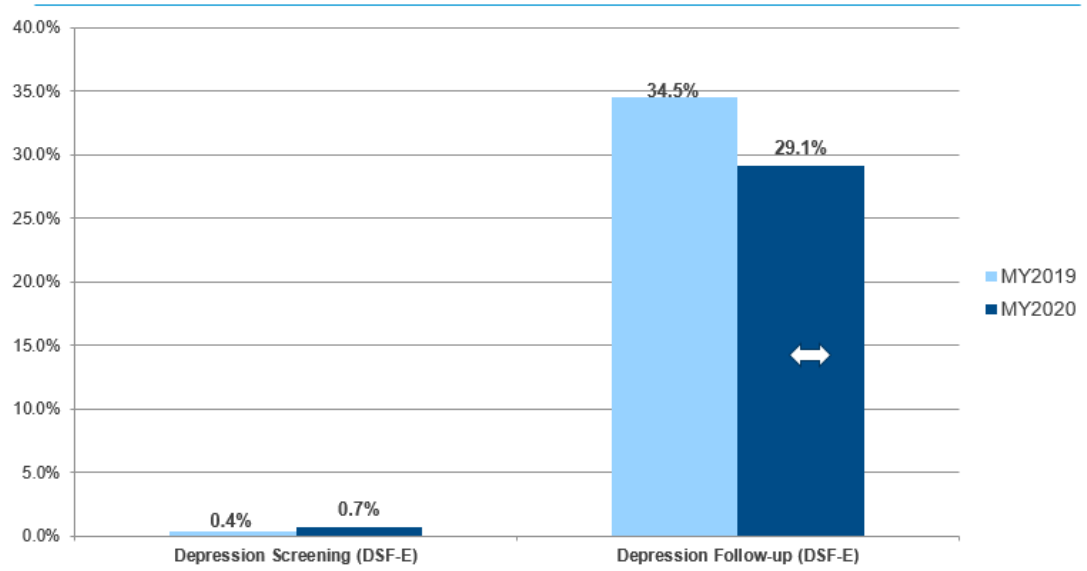
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. DSF requires providers to screen patients ages 12 years and older for clinical depression using standardized depression screening tools AND if positive, provide and document a follow-up plan. Since DSF is still a relatively new measure, there is currently no benchmark to evaluate performance. CalOptima had been tracking the measure and conducted improvement activities.

A. Interventions

1. The BHI quality team created a depression factsheet and posted to the CalOptima website for virtual distribution to allow providers to share information with members during telehealth visits. The factsheet included information on depression screenings.
2. The BHI quality team created and distributed a provider letter to remind providers of the importance of depression screenings as well as communicate standards and guidelines regarding the measure. The letter also included a link to the depression factsheet located on the CalOptima website to share with members they serve.
3. The BHI quality team created an article, "Understanding Depression," which included information on depression screenings. The article was included in the Summer 2021 Medi-Cal member newsletter.

B. Findings



*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

C. Analysis

For MY 2020, CalOptima's HEDIS rate for the Depression Screening was 0.7% for members who were screened for clinical depression using a standardized instrument while the Follow-Up on Positive Screen rate was 29.1%. The table shows an

improved rate for the Depression Screening phase, but the rate decreased by 5.4% for the Follow-Up care from the prior year. The drop in the percentage rate for members who received follow-up care within 30 days is attributed to COVID-19 pandemic and related social distancing requirements. Currently, NCQA has not released the percentile for DSF, which is used for benchmark. We are not able to set the goal because the goal is based on the percentile.

D. Barriers

1. Data collection from providers continues to be a barrier because of the lack of a mechanism for capturing provider data. The BHI quality team is exploring alternate solutions to incorporate tools into CalOptima's internal system to collect data from providers.
2. The COVID-19 pandemic dramatically changed provider educational events. As a result, there was no opportunity to promote depression screening and treatment in the community. Planning for future educational activities may be a challenge considering the unknown impact of the current health crisis.
3. Due to the COVID-19 pandemic, the number of members scheduling routine/preventive care appointments (i.e., well-child visits, annual physical exams) declined resulting in fewer opportunities for providers to conduct depression screenings.

E. Opportunities for Improvement

1. Develop member information encouraging them to schedule routine/annual visits to increase opportunities for depression screenings.
2. Develop a HEDIS reporting tip sheet to educate providers on the importance of depression screening, available screening tools and treatment options.
3. Continue to explore how to incorporate tools into CalOptima's internal system to gather data from providers.
4. Continue to work with Provider Relations on identifying alternative ways of hosting educational events.

Chronic Conditions

Improve HEDIS Measures Related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control

Comprehensive Diabetes Control (CDC): HbA1c Testing and Eye Exam

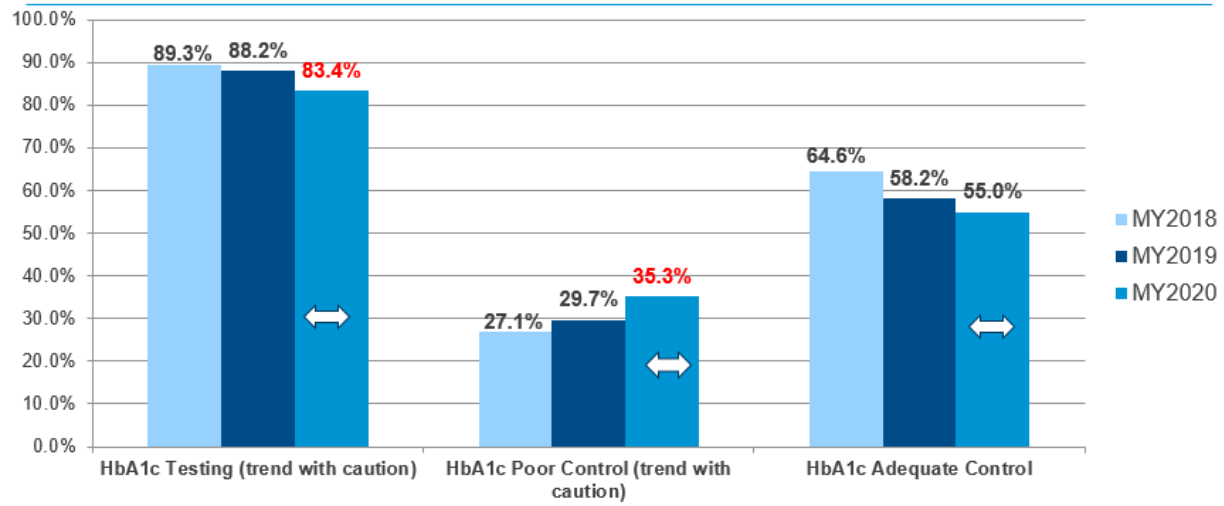
The HbA1c Testing HEDIS and MCAS measure is classified as members 18–75 years of age with diabetes (type 1 and type 2) who had an HbA1c test within the measurement year. HbA1c Poor Control (>9.0%) is defined as members 18–75 years of age with diabetes (type 1 and type 2) who had a recent HbA1c level of >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year (lower is better). HbA1c Adequate Control (HbA1c <8.0%) is for members 18–75 years of age with diabetes (type 1 and type 2) who had an HbA1c test result of <8.0% within the measurement year.

HbA1c Testing and Control

Medi-Cal

The CDC Figure 1a below shows the trend analysis for the Medi-Cal CDC HbA1c Testing measure for MY2018–20. HbA1c Testing measure did not met the 33rd percentile meeting the MPL. HbA1c Poor Control met the 33rd percentile (lower is better). HbA1c Adequate Control sub-measure met the 66th percentile.

CDC Figure 1a: Medi-Cal HbA1c Testing and Control



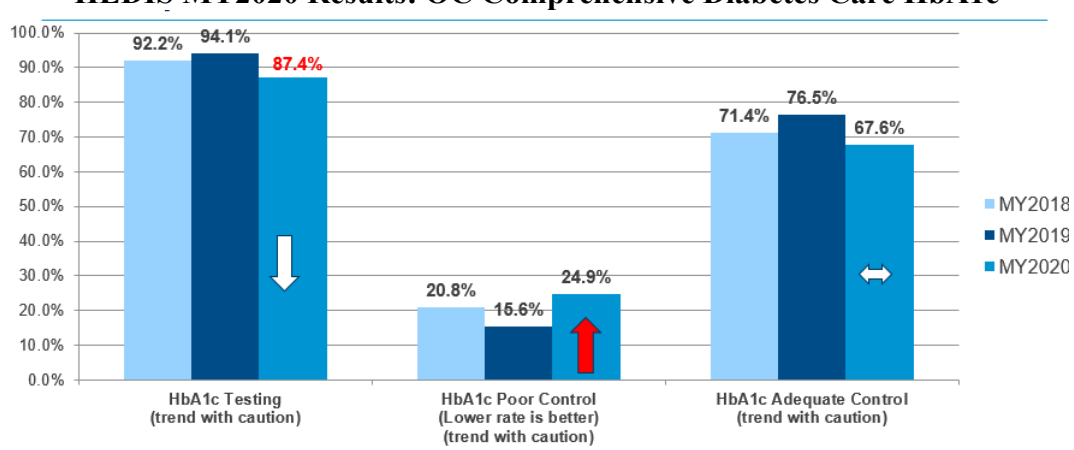
HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
HbA1c Testing	86.86%	90.27%	92.70%	88.79%	
HbA1c Poor Control (>9.0%) (Lower is better)	42.58%	33.80%	27.98%	37.47%	MPL, P4V
HbA1c Adequate Control (<8.0%) ++	47.69%	54.26%	60.77%	58.37%	HPR

**Red is less than 33rd percentile; Green is met the goal; Purple is MPL met, ++measure triple weighted for Health Plan Ratings ↓↑ statistically higher or lower ↔ statistically no difference ** HPR is Health Plan Ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

OneCare

The CDC Figure 1b below shows the trend analysis for the OneCare CDC HbA1c Testing measure for MY2018–2020. A1c Testing measure did not met the goal of 94.89%. HbA1c Poor Control met the 66th percentile. HbA1c Adequate Control sub-measure met the 33rd percentile.

CDC Figure 1b: OC HbA1c Testing and Control



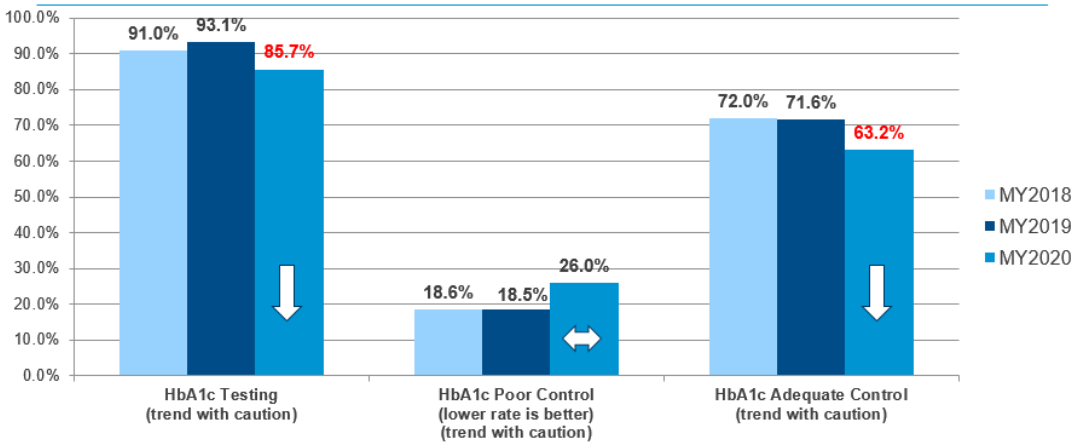
HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - HbA1c Testing	93.75%	95.82%	97.32%	94.89%	CMS
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%) #	39%	28%	15%	15%	Star
Comprehensive Diabetes Care (CDC) - HbA1c Adequate Control (<8.0%)	63.26%	71.97%	77.78%	77.78%	CMS

**Red is less than 33rd percentile; Green is met the goal; ***Star cut points are previous year*
↓↑ statistically higher or lower ↔ statistically no difference

OneCare Connect

The CDC Figure 1c below shows the trend analysis for the OneCare Connect CDC HbA1c Testing measure for MY2018–2020. HbA1c Testing measure did not met the goal of 94.89%. HbA1c Poor Control met the 66th percentile (lower is better). HbA1c Adequate Control sub-measure did not meet the goal of 71.97%.

CDC Figure 1c: OCC HbA1c Testing and Control



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - HbA1c Testing	93.75%	95.82%	97.32%	94.89%	CMS
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%) **	39%	28%	15%	15%	Star, P4V
Comprehensive Diabetes Care (CDC) - HbA1c Adequate Control (<8.0%)	63.26%	71.97%	77.78%	71.97%	CMS

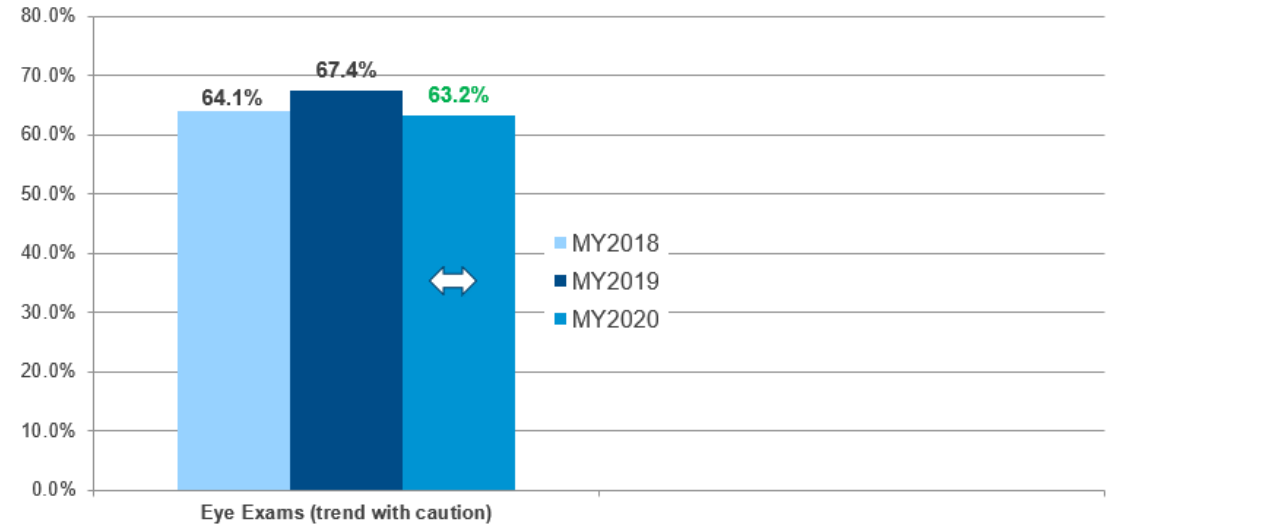
**Red is less than 33rd percentile; Green is met the goal; ***Star cut points are previous year*
↓↑ statistically higher or lower ↔ statistically no difference

Improve HEDIS Measures Related to Comprehensive Diabetes Care (CDC): Eye Exam

CDC Eye Exam
The CDC Eye Exam measure includes members 18–75 years of age with diabetes mellitus (type 1 and type 2) who had one of the following:
• A retinal or dilated eye exam in the measurement year.
• Tested negative for retinopathy in the year prior to the measurement year.
• Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Medi-Cal
The CDC Figure 2a below shows the trend analysis for the Medi-Cal CDC Eye Exam measure for MY2018–2020. Eye Exam measure met the 66th percentile of the MPL.

CDC Figure 2a: Medi-Cal Eye Exam



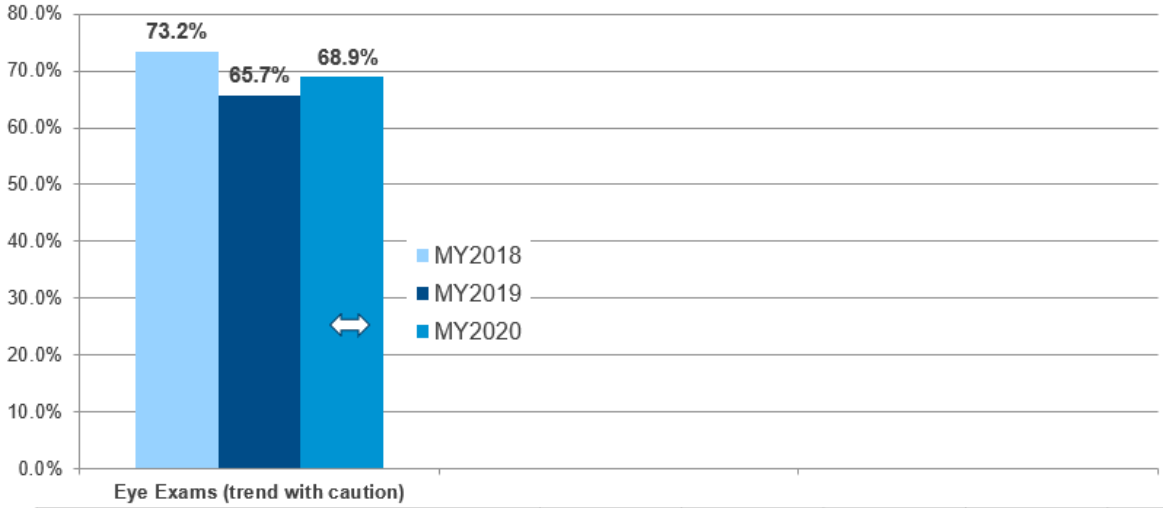
HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Eye Exams	54.55%	61.56%	69.59%	58.64%	HPR

**Red is less than 33rd percentile; Green is met the goal; Purple is MPL met, ++measure triple weighted for Health Plan Ratings*
*↓↑ statistically higher or lower ↔ statistically no difference ** HPR is Health Plan Ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

OneCare
The CDC Figure 2b below shows the trend analysis for the OneCare CDC Eye Exam measure for MY2018–2020. Eye Exam measure did not meet the 33rd percentile and did not meet the goal of 78%.

CDC Figure 2b: OneCare Eye Exam

HEDIS MY2020 Results: OC Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - Eye Exams	69%	73%	78%	78%	Star

**Red is less than 3-Star or 50th percentile; Green is met the goal; ** Star cut points are previous year*

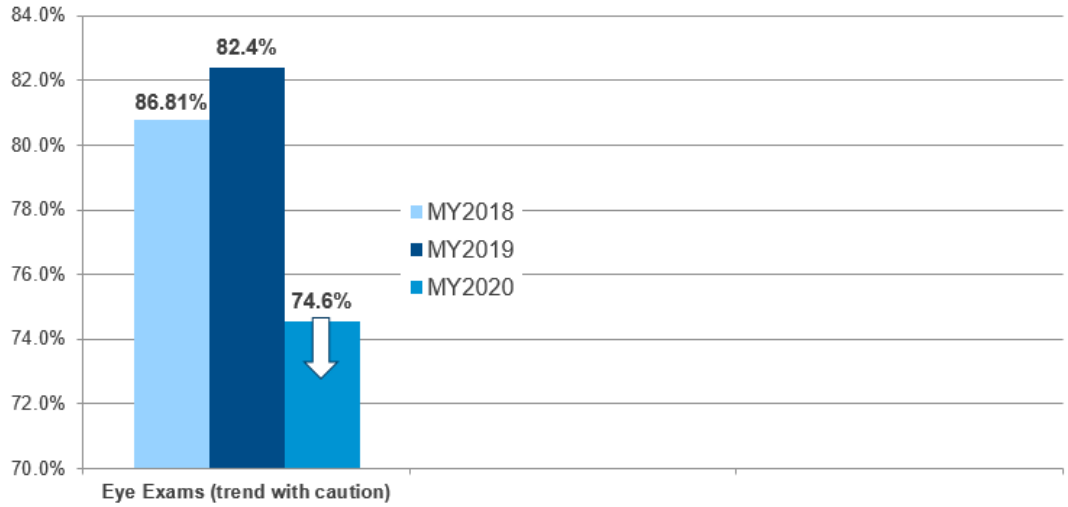
↓↑ statistically higher or lower ↔ statistically no difference

OneCare Connect

The CDC Figure 2c below shows the trend analysis for the OneCare Connect CDC Eye Exam measure for MY2018–2020. Eye Exam measure met the 66th percentile but did not meet goal of 78%.

CDC Figure 2c: OneCare Connect Eye Exam

HEDIS MY2020 Results: OCC Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - Eye Exams	69%	73%	78%	78%	Star, P4V

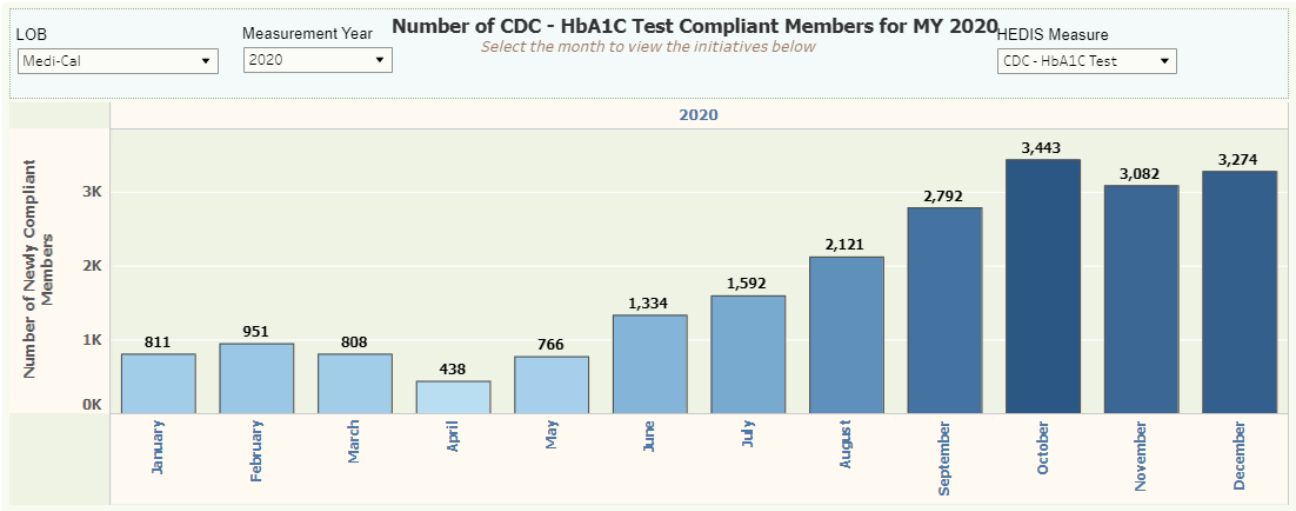
**Red is less than 3-Star or 50th percentile; Green is met the goal; ** Star cut points are previous year*

↓↑ statistically higher or lower ↔ statistically no difference

CDC HbA1c Compliant Members for HEDIS 2020

Figure 3 below shows the HbA1c initiatives for the HEDIS 2021 (MY2020) year. The data shows a gradual increase on a month-to-month basis. The largest increase is evident from June 2020 to October 2020. A slight decrease occurred in November 2020. The implementation of the Member Health Reward and Diabetes Health Coaching initiative helped with increasing member compliance in December 2020.

CDC Figure 3: HbA1c Compliant Members for HEDIS 2020



CDC Table 1: CDC HbA1c 2020 Interventions

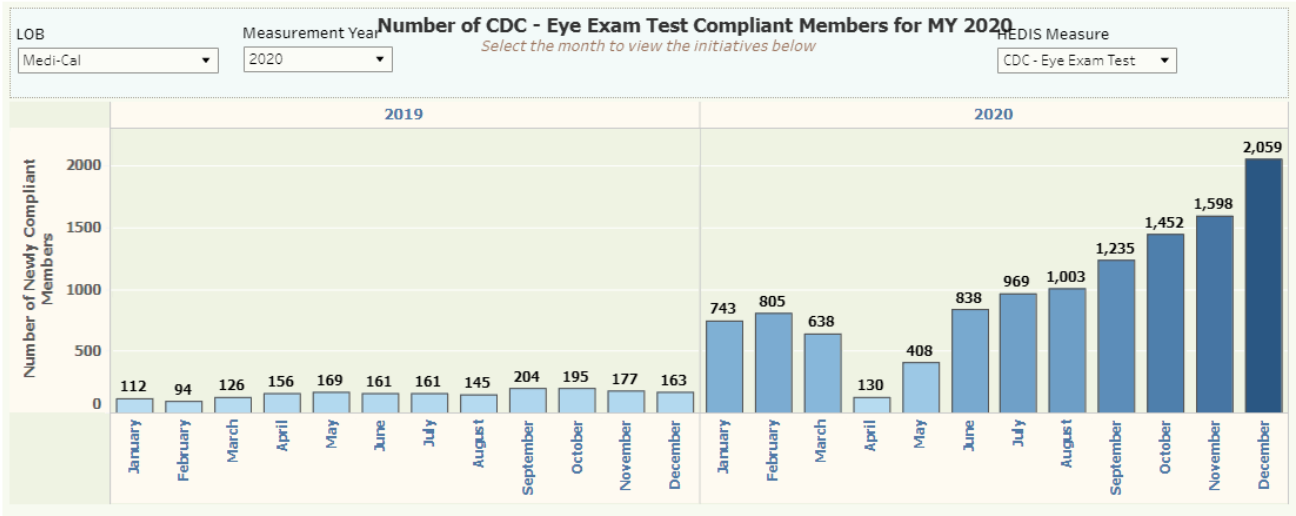
Initiative	Start Date	End Date	Outreach Population	Description
Member Health Reward	1/1/2020	12/31/2020	20,532 members	$25 member health reward for completing a HbA1c Test
Member Outreach	1/1/2020	12/31/2020	Members: MC: 874; OC: 8; OCC: 88	Diabetes educational mailings
			Members: MC: 1,014; OC: 8; OCC: 107	Health Coach Care Plan outreach for Diabetes
Provider Update Newsletter	12/20/2020	12/20/2020	All health networks and CCN providers	Provider Fax Blast (Provider Update): CalOptima 2021 Member Health Rewards Program
Social Media Posting	11/9/2020	11/9/2020	All, public	Diabetes Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	(Posted member health reward forms on website)

CDC: Exam Compliant Members for HEDIS 2020

CDC Figure 4 below shows the Eye Exam initiatives for the HEDIS 2020 reporting year. The bar graph is split into two sections: the 2019 measurement year section contains the number of members that had a negative retinal or dilated eye exam (negative for retinopathy) which would count toward HEDIS 2021 reporting year. The 2020 measurement year section contains the number of members

who had a diabetic retinal eye exam due to a date of service in 2020. For 2019, the rates varied from one month to another, though the data shows a gradual increase month to month from May 2020 to December 2020. The implementation of the Diabetes Health Coaching initiative helped with increasing the figures gradually month to month in 2020. During the months of April and May 2020 there was a significant delay in the rates as a consequence of the COVID-19 pandemic.

CDC Figure 4: Eye Exam Compliant Members for HEDIS 2020



CDC Table 2: CDC Eye Exam 2020 Interventions

Initiative	Start Date	End Date	Outreach Population	Description
Member Health Rewards	1/1/2020	12/31/2020	15,196 members	$25 member health reward for completing a Diabetes Eye Exam
Member Outreach	1/1/2020	12/31/2020	Members: MC: 874; OC: 8; OCC: 88	Diabetes educational mailings
			Members: MC: 1,014; OC: 8; OCC: 107	Health Coach Care Plan outreach for Diabetes
Provider Update Newsletter	12/20/2020	12/20/2020	All health networks and CCN providers	Provider Fax Blast (Provider Update): CalOptima 2021 Member Health Rewards Program
Social Media Posting	11/9/2020	11/9/2020	All, public	Diabetes Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	(Posted member health reward forms on website)

2020 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. HbA1c and Diabetic Eye Exam Member Health Rewards

A. Intervention

In 2019, the targeted member health rewards population was eligible members who were non-compliant in the HEDIS 2020 CDC HbA1c testing (n=15,196) measure and the CDC Eye Exam (n=15,196) measure. In 2020, targeted eligible members who were non-compliant

in the HEDIS 2021 CDC HbA1c testing (n=20532) and CDC Eye Exam (n=15,196) measures were eligible for the $25 gift card member health reward if they completed the HbA1c Test and/or diabetic eye exam. In addition to the member health rewards, the members received information on statin medication and diabetes health coaching services. Both HbA1c Test and Diabetic Eye Exam member health reward programs were only for Medi-Cal.

B. Findings

CDC Table 7 shows the Medi-Cal members who were eligible for the member incentive for HbA1c Testing and Diabetic Eye Exams, and the response rate for each respective incentive.

CDC Table 7: MY2019–20 Member Incentive Medi-Cal
Medi-Cal HbA1c and Eye Exam Member Incentive

Measure	HEDIS Non-Compliant Members Eligible		Health Reward Forms Received		Response Rate	
	2019	2020	2019	2020	2019	2020
HbA1c Test	15,196	20,532	510	863	3.36%	4.20%
Diabetic Eye Exam	5,466	15,196	163	736	2.98%	4.84%

CDC Table 8 shows the counts of Medi-Cal member incentives received and the response rate.

CDC Table 8: MY2019–20 HbA1c Testing and Eye Exam Member Incentive Medi-Cal HEDIS Participation Rates

HbA1c Test Health Reward Forms	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Health Reward Participation Rate
2019	510	455	25,338	1.80%
2020	863	843	26,487	3.18%
Eye Exam Health Reward Forms	**Forms Received**	**HEDIS Qualified**	**HEDIS Denominator**	**HEDIS Health Reward Participation Rate**
2019	163	152	25,338	0.60%
2020	736	685	26,487	2.59%

C. Analysis

1. In MY 2019 of the 15,196 who were eligible for the HbA1c Test reward, 510 submitted HbA1c Test reward forms, yielding a 3.36% response rate. Out of the 510 submitted A1c Test reward forms, 455 remained as HEDIS Qualified (counted toward HEDIS measure). The 455 HEDIS Qualified out of the 25,338 denominator yielded a 1.80% response rate of HEDIS eligible submissions.

2. In MY 2019 of the 5,466 who were eligible for the Eye Exam reward, 163 submitted Eye Exam reward forms, yielding a 2.98% response rate. Out of the 163 submitted Eye Exam reward forms, 152 remained as HEDIS Qualified (counted toward HEDIS measure). The 152 HEDIS Qualified out of 25,338 denominator yielded a 0.60% response rate of HEDIS eligible submissions.
3. In MY 2020 of the 20,532 who were eligible for the HbA1c Test reward, 863 submitted HbA1c Test reward forms, yielding a 4.20% response rate. Out of the 863 submitted A1c Test reward forms, 843 remained as HEDIS Qualified (counted toward HEDIS measure). The 843 HEDIS Qualified out of 26,487 denominator yielded a 3.18% response rate of HEDIS eligible submissions.
4. In MY 2020 of the 15,196 who were eligible for the Eye Exam reward, 736 submitted Eye Exam reward forms, yielding a 4.84% response rate. Out of the 736 submitted Eye Exam reward forms, 685 remained as HEDIS Qualified (counted toward HEDIS measure). The 685 HEDIS Qualified out of 26,487 denominator yielded a 2.59% response rate of HEDIS eligible submissions.
5. Overall Response Rate and HEDIS Member Health Reward Participation Rate increased when comparing the results between MY 2019 and MY 2020.

D. Barriers

1. One of the largest barriers for the Eye Exam incentive program was the delay with the VSP contracted vision provider not permitting members with diabetes to get an annual diabetic eye exam in 2020. Although efforts to correct the contract have permitted diabetic members to get their exam on an annual basis, due to a delay in updating the eligibility file sent to VSP with a diabetes identifier, CalOptima members were being turned away by VSP, although eligible for the exam. This was addressed in 2021 with an update to the contract as well as visibility added to the eligibility file.
2. Members may still be reluctant to go to their provider's office due to the COVID-19 pandemic.
3. Incomplete Forms: HbA1c Test reward forms regularly came back with the HbA1c value field empty, or it was clear members had filled out the form themselves with a blood sugar value reading instead of an HbA1c Test value. In addition, some of the providers did not complete the retinopathy exam result on the form, often returning the forms with that field blank. With eye exam reward forms, there were some providers who did not stamp the forms. Many scribble initials and it is hard to figure out who performed the eye exam.
4. Incorrect Information: Many members received the forms in the mail and simply filled out their information and submitted without having the service done. Some of those submitted forms used old dates of service that do not qualify.
5. Members give the form to their doctor assuming the provider will fax to CalOptima. CalOptima often does not gets those submissions.
6. HbA1c testing is usually done quarterly or as directed by a provider. This may lead to member lab visit fatigue due to frequent lab visits for testing.
7. In 2020, CalOptima did not conduct member mailers for HbA1c and Eye Exam due to budget limits with mailing health reward forms to eligible members.
8. Data access issues: lack of data or missing lab data in the Electronic Health Record (EHR) impacted the measure by not showing members who were truly compliant and/or noncompliant.

E. Opportunities for Improvement

1. In an effort to promote the importance of annual diabetic eye exams, regardless of whether the member falls into the HEDIS denominator or not, the diabetes reward will be available to all CalOptima members identified with diabetes mellitus to encourage yearly eye exams.
2. Improve and place a greater emphasis on compliance with Diabetes HbA1c Testing and Eye Exam. Along with all other incentives, there will be a concerted effort for greater promotion and marketing of the diabetes member rewards through the health networks, CCN providers and in the community.
3. Reiterate the importance of completely filling out the member health reward forms and following through with the submission of forms given by the member to all contracted providers, through provider fax updates or provider outreach calls.
4. Consider room in the budget for mailing out health reward forms to eligible members to increase awareness.
5. Leverage social media as a platform to encourage HbA1c Tests and Eye Exams.
6. Seek an allocation of resources to resolve the lack of data/missing lab data and access to EHR to improve data collection.
7. Collaborate closely with community partners when implementing health rewards to raise awareness.
8. Conduct current member data analysis considering age groups, ethnicity and ZIP codes for noncompliance trends and to strategize for better outcomes.

2021 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. Emerging Risk Health Coaching Telephonic Outreach

A. Intervention

In an effort to address emerging risk in a timely fashion, eligible members with diabetes who had an HbA1c test result below 8.0% but tested between 8.0% and 9.0% in their most recent HbA1c test were identified as emerging risk members. Telephonic outreach is conducted by a health coach to identify solutions for emerging risk members to manage their HbA1c levels below 8.0%.

B. Findings

CDC Table 9: 2021 Health Coaching Outreach for All Programs: MC, OC and OCC

Year	Qtr	LOB	Starting Denominator	Members assigned to a Health Coach	Emerging Risk Members Successful Outreach	Emerging Risk Members Unsuccessful Outreach
2021	Q1	OC	5	5	3	0
2021	Q1	OCC	94	20	10	3
2021	Q1	MC	817	75	47	2
2021	**Q1**	**Total**	**916**	**100**	**60**	**5**

2021	Q2	OC	5	5	4	1
2021	Q2	OCC	108	55	34	3
2021	Q2	MC	712	148	99	11
2021	**Q2**	**Total**	**825**	**208**	**137**	**15**

C. Analysis

In Q1 2021 for OneCare (OC), five emerging risk members were assigned for telephonic Health Coaching outreach with three successful outreach calls. In Q2 2021, five emerging risk members were assigned for telephonic Health Coaching outreach with four successful outreach calls. This resulted in a 60% successful outreach rate in Q1 2021 and an 80% successful outreach rate in Q2 2021 for OC.

In Q1 2021 for OneCare Connect (OCC), 20 emerging risk members were assigned for telephonic Health Coaching outreach with 10 successful outreach calls. In Q2 2021, 55 emerging risk members were assigned for telephonic Health Coaching outreach with 34 successful outreach calls. This resulted in a 50% successful outreach rate in Q1 2021 and a 61.81% successful outreach rate in Q2 2021 for OCC.

In Q1 2021 for Medi-Cal (MC), 75 emerging risk members were assigned for telephonic Health Coaching outreach with 47 successful outreach calls. In Q2 2021, 148 emerging risk members were assigned for telephonic Health Coaching outreach with 99 successful outreach calls. This resulted in a 62.67% successful outreach rate in Q1 2021 and a 66.89% successful outreach rate in Q2 2021 for MC.

When comparing Q1 2021 and Q2 2021 results collectively, among those that were assigned to a Health Coach, the successful outreach rate increased from 60% (60/100) in Q1 2021 to 65.87% (137/208) a 5.87 percentage point increase.

D. Barriers

1. Limited capacity for the health educators to conduct outbound calls due to their competing volume of daily tasks.
2. Difficulty with scheduling appointments. Appointments are very far away, especially with endocrinologist due to limited office hours.
3. With the COVID-19 pandemic, telehealth appointments were difficult for some members due to the lack of access to a smartphone or not understanding the instructions on how to connect to video calls.
4. Members relying more on natural remedies to reduce their blood sugar.
5. Members face challenges with access to broadband/internet based on their economic status or place of residence.
6. Members may require transportation to attend appointments and may not be aware about their transportation benefits.

E. Opportunities for Improvement

1. Instruct Health Coaches to assist members with scheduling appointments whenever possible. Teach members how to navigate the health system and telehealth appointments. Encourage members to communicate needs and challenges timely to their provider.
2. During outbound calls conduct a short questionnaire screening for SDOH and connect members with other resources to assist specific needs.
3. Update telephonic scripting to mention resources and telehealth.
4. Seek ways to improve data needs and streamline how members are assigned moving away from manual assigning to a more automated method.
5. Conduct a multilayered analysis of membership data by volume, ZIP code, ethnicity and age groups to determine additional SDOH that may be creating barriers for CalOptima members. Moving forward, additional analysis is needed to create appropriate programs that will make an impact to address barriers and inequities among the targeted groups in the regions we serve.

CDC Table 10 below shows the 10 highest volume groups by member ethnicity. Future targeted outreach should factor in member demographics (e.g., ethnicity and ZIP code) to improve outreach efforts. Based on the data shown below, the Black population had the lowest CDC rate (75.96%), which indicates the need to focus on that group and develop a targeted strategy for improvement.

CDC Table 10: 2021 Health Coaching Outreach for All Programs: MC, OC and OCC

Ethnicity Code (group)	CDC A1c Testing Numerator Rate	Numerator Count	Denominator Count	Percentage of Total Population	Impact on HEDIS Rate
Hispanic	82.57%	11,988	14,519	41.99%	34.67%
White	77.27%	4,228	5,472	15.83%	12.23%
Vietnamese	87.25%	4,271	4,895	14.16%	12.35%
No response, client declined to state	81.84%	3,551	4,339	12.55%	10.27%
Other	78.04%	910	1,166	3.37%	2.63%
Filipino	85.25%	734	861	2.49%	2.12%
Asian or Pacific Islander	82.30%	693	842	2.44%	2.00%
Black	75.96%	496	653	1.89%	1.43%
Korean	88.23%	517	586	1.69%	1.50%
Asian Indian	84.19%	378	449	1.30%	1.09%

Additional Planned Diabetes Activities for 2021:

1. Publish articles in the Medi-Cal newsletter about the importance of staying healthy by managing diabetes during the COVID-19 pandemic.
2. Collaboration with various health networks on promoting health rewards via multiple ongoing campaign outreach efforts.
3. Targeted round-robin identification of high-risk members with diabetes for telephonic health coaching on outstanding exams and tests needed.
4. Ongoing outreach calls to emerging risk population of diabetics who were well controlled, but now have an A1C between ≥8.0% and ≤9.0%.

5. Ongoing quarterly provider fax reports of diabetic members NOT on a statin.
6. Ongoing SPD quarterly mailings to educate members with diabetes NOT on a statin about the benefits of statin use in preventing cardiovascular risk and the importance of having the discussion with their provider.
7. Social media messages for diabetes awareness month slated for November 2021.

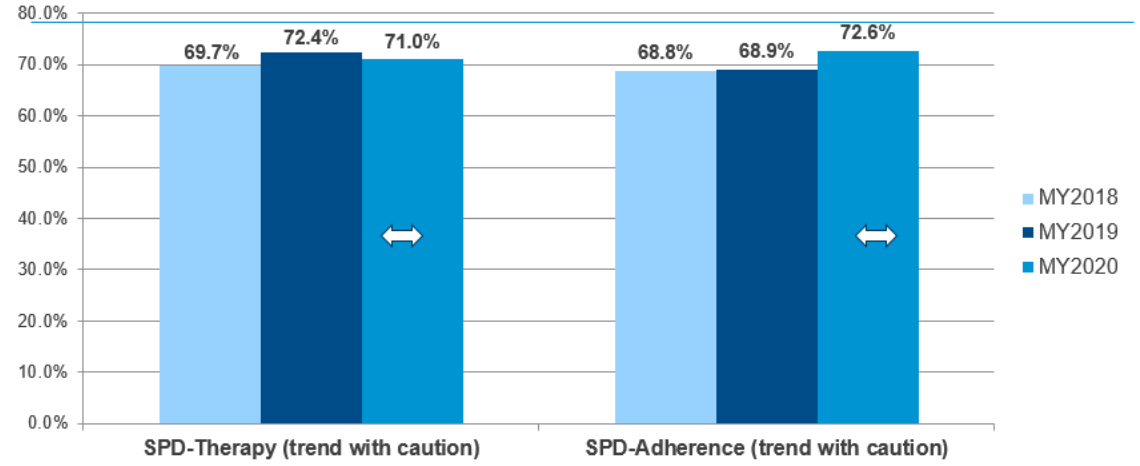
Statin Therapy for Patients with Diabetes (SPD)

SPD Therapy measure is classified as members 40–75 years of age with diabetes mellitus who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and who received Statin Therapy during the measurement year. This measure includes members who were dispensed at least one statin medication of any intensity during the measurement year.

SPD Adherence measure is described as members 40–75 years of age with diabetes mellitus who do not have ASCVD and who received Statin Therapy during the measurement year. Statin Adherence is further classified as members who remained on a statin medication of any intensity for at least 80% of the treatment period.

SPD Figure 1 below shows a trend analysis for Medi-Cal SPD measure for MY2018–20. SPD therapy sub-measure met the 66th percentile for MY2020 but did not meet the goal of 71.82%. For the SPD adherence sub-measure MY2020, CalOptima did achieve the 66th percentile and met the goal of 69.58%.

SPD Figure 1: HEDIS Trending Rates 2018–20



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) — therapy	63.45%	67.59%	71.82%	71.82%	HPR
Statin Therapy for Patients with Diabetes (SPD) — adherence	60.81%	67.43%	75.72%	69.58%	HPR

**Red is less than 33rd percentile; Green is met the goal; Purple is MPL met, ++measure triple weighted for Health Plan Ratings*
*↓↑ statistically higher or lower ↔ statistically no difference ** HPR is Health Plan Ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

SPD Table 1: SPD List of Initiatives

Initiative	Start Date	End Date	Outreach Population (By LOB)	Description
SPD Statin Member Mailing	1/1/2020	12/31/2020	MC: 5,047 members OC: 63 members OCC: 603 members	Quarterly mailings sent to members to improve SPD Statin Therapy and Statin Adherence measures
SPD Provider Fax	1/1/2020	12/31/2020	**MC 2020** Q1: 5,665 Q2: 5,989 Q3: 6,086 Q4: 5,807 **OC 2020** Q1: 64 Q2: 69 Q3: 88 Q4: 88 **OCC 2020** Q1: 663 Q2: 722 Q3: 744 Q4: 700	CalOptima's Pharmacy Management department sent a list of members to providers for member outreach in order to improve SPD Statin Therapy and Statin Adherence measures. These members were either missing statin therapy or on a current statin with a calculated adherence rate <80%, suggesting non-adherence.

2020–21 Statin Therapy for Patients With Diabetes (SPD) Initiatives: Medi-Cal, OC, and OCC

1. Pharmacy Management Department SPD Provider Faxes 2021

A. Intervention

CalOptima's Pharmacy Management department sent a list of members to providers for member outreach to improve SPD Statin Therapy and Statin Adherence measures. These members were either missing statin therapy or on a current statin with a calculated adherence rate <80%, suggesting non-adherence. The lists are provided to ask providers to follow-up with members out of adherence.

B. Findings

SPD Table 2: Pharmacy Management Department SPD Provider Faxes Membership Breakdown by Line of Business

Number of Members Faxed to Providers												
	Quarter 1 2021				Quarter 2 2021				Quarter 3 2021			
Sub-measure	MC	OC	OCC	Total	MC	OC	OCC	Total	MC	OC	OCC	Total
Statin Needed	3,285	58	376	3,719	3,280	58	360	3,698	4,239	61	455	4,755
Statin Non-Adherence	2,244	27	299	2,570	1,500	23	202	1,725	2,044	19	267	2,330
Total	5,529	85	675	6,289	4,780	81	562	5,423	6,283	80	722	7,085

C. Analysis

As of Quarter 3 2021, HEDIS prospective rates, as outlined in the introduction above, for the number of Medi-Cal members receiving statins is 68.34% (slightly higher compared with August 2020 at 67.70%). The rate for OneCare members is 79.14% (higher compared with

August 2020 at 72.73%). The rate for OneCare Connect members is 78.12% (slightly higher compared with August 2020 at 77.95%).

D. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the increased risk of cardiovascular complications associated with diabetes mellitus.

E. Opportunities for Improvement

1. The quarterly faxes will continue to be sent to providers for members who are missing or who are non-adherent to their statin medication in a continued effort to coordinate care and ensure providers are aware of current clinical standards for diabetes care.
2. Continue sending educational newsletters to primary care providers outlining the importance of statin use for cardiovascular risk reduction and formulary medication options.

2. Quarterly SPD Statin Member Mailings

A. Intervention

To reinforce the SPD provider faxes, a quarterly complementary member mailing was created. The main purpose of the mailing is to educate members with diabetes mellitus who are missing a statin prescription or who are non-adherent to their statin prescription. Efforts aim to encourage members to have a conversation with their PCP about whether a statin is right for them to reduce cardiovascular risk as a preventative measure. The PHM department sent quarterly mailings to members to improve SPD Statin Therapy and Statin Adherence measures. Identified members were either missing statin therapy or on a current statin prescription with a calculated adherence rate <80%, suggesting non-adherence. The mailer included a cover letter prompting the member to ask their doctor if a statin medication was right for them along with educational material about statin medications.

B. Findings

SPD Table 3: SPD Quarterly Statin Member Mailings

	Q1 2021			Q2 2021		
LOB	Letters Sent: Non-Adherent Members	Adherent Members After Mailing	Adherence Rate by Q2 2021	Letters Sent: Non-Adherent Members	Adherent Members After Mailing	Adherence Rate by Q3 2021
OC	27	17	62.96%	71	18	25.35%
OCC	290	197	67.93%	464	84	18.10%
Medi-Cal	2,183	1,348	61.75%	3,947	402	10.18%
Total	**2,500**	**1,562**	62.48%	**4,482**	**504**	11.24%

C. Analysis

In Q1 2021, the adherence rate by Q2 2021was 62.96% for OC, 67.93% for OCC and 61.75% for Medi-Cal. Overall, there was a 62.48% adherence rate across the lines of business, by the next quarter. In Q2 2021, the adherence rate by next quarter was 25.35% for OC, 18.10% for OCC and 10.18% for MC. Overall, we had a 11.24% adherence rate by the next quarter in Q2 2021. Adherence rates declined from Q1 2021 to Q2 2021.

D. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic or provider offices may not have been open or readily scheduling appointments.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the increased risk of cardiovascular complications associated with diabetes mellitus.
4. Member mailings cannot be directly correlated with adherence.
5. The data for the quarterly member mailing lists heavily depends on when the provider fax list from the Pharmacy Management department are received.
6. The member mailing for Q3 2021 was delayed due to other competing member communication priorities related to the COVID-19 pandemic.
7. SDOH impact the adherence and ability to maintain a healthy lifestyle for Medi-Cal members. General economic stability is a struggle for Medi-Cal members. Income instability directly impacts the ability to purchase food and may result in food insecurity, which affects members' ability to maintain a healthy lifestyle.
8. Another SDOH that impacts Medi-Cal members' ability to maintain a healthy lifestyle is the access to healthy food options. Healthy foods have a positive impact on a members' overall cardiovascular health.

E. Opportunities for Improvement

1. Continue to publish newsletter articles about the importance of obtaining diabetic laboratory testing and regular physician examinations, and the impact of statin use on heart health for members with diabetes mellitus.
2. Obtain the membership data from the Pharmacy Management department sooner to give additional time for the member mailing logistics preparations.
3. Continue the quarterly mailers to members in 2022 who are non-adherent with their statin medications.
4. The Pharmacy Management department sends communications to members to ensure awareness about the ability to get medications for several months instead of only a one-month supply.
5. Conduct a multilayered analysis of membership data by volume, ZIP code, ethnicity and age groups to determine additional social determinants of health that may be creating barriers for CalOptima members. Moving forward, additional analysis is needed to create appropriate programs that will make an impact to address barriers and inequities among the targeted groups in the regions we serve.

SPD Table 4 below shows the 10 highest volume groups by member ethnicity. Future targeted outreach should factor in member demographics (e.g., ethnicity and ZIP code) to improve outreach efforts. This allows CalOptima to have a deeper understanding about the membership composition, ethnic populations to focus on, and develop programs that address equity opportunities. As an example, based on the data shown below, the Black population had the lowest SPD rate (62.81%). This indicates a need to focus on this membership composition and develop a targeted strategy to help improve outcomes.

SPD Table 4: MY2020 SPD Therapy Rate by Member Ethnicity, 10 Highest Volume Groups

Ethnicity	SPD Numerator Rate	Numerator Count	Denominator Count	Percentage of Total Population	Impact on HEDIS Rate
Hispanic	69.30%	5,869	8,469	39.18%	27.15%
Vietnamese	82.61%	3,073	3,720	17.21%	14.22%
White	64.50%	2,142	3,321	15.36%	9.91%
No response, client declined to state	70.50%	1,921	2,725	12.61%	8.89%
Other	73.34%	531	724	3.35%	2.46%
Asian or Pacific Islander	75.93%	467	615	2.85%	2.16%
Filipino	84.14%	435	517	2.39%	2.01%
Korean	76.62%	295	385	1.78%	1.36%
Black	62.81%	228	363	1.68%	1.05%
Asian Indian	71.17%	200	281	1.30%	0.93%

2021 Statin Therapy for Patients With Cardiovascular Disease (SPC) Initiatives: Medi-Cal, OC and OCC

Pharmacy Management Department SPC Provider Faxes 2021

A. Intervention

CalOptima's Pharmacy Management department sent a list of members to providers for member outreach in order to improve SPC Statin Therapy and Statin Adherence measures. These members were either missing a moderate to high intensity statin therapy or were identified as non-adherent to a moderate to high intensity statin using a proportion of days covered (PDC) calculation rate of <80%.

B. Findings

Table 2 shows the number of faxes by the Pharmacy Management department sent to targeted providers for members needing statins or members who were non-adherent with statins.

SPC Table 2: Pharmacy Management Department SPC Provider Faxes 2021

Pharmacy Management Department SPC Provider Faxes 2021												
Number of Unique Member Faxes												
	Quarter 1 2021				Quarter 2 2021				Quarter 3 2021			
Sub measure	MC	OC	OCC	Total	MC	OC	OCC	Total	MC	OC	OCC	Total
Statin Needed	216	16	77	309	284	2	31	317	238	5	75	318
Statin Non-Adherence	236	7	59	302	81	2	13	96	168	4	32	204
Total	452	23	136	611	365	4	44	413	406	9	107	522

C. Analysis

As of Quarter 3 2021, HEDIS prospective rates for the number of Medi-Cal members receiving a moderate to high intensity statin is 78.76% (slightly higher compared with August 2020 at 78.34%). The rate for OneCare members is 87.27% (higher compared with August 2020 at 71.15%). The rate for OneCare Connect members is 79.47% (higher compared with August 2020 at 78.46%).

D. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the decreased morbidity and mortality associated with moderate to high intensity statin use in the presence of cardiovascular disease.

E. Opportunities for Improvement

1. Quarterly faxes will continue to be sent to providers for members who are missing a moderate to high intensity statin prescription or those who are identified as non-adherent to a moderate to high intensity statin in a continued effort to coordinate care and ensure providers are aware of current clinical standards for cardiovascular disease management.
2. Continue sending educational newsletters to primary care providers outlining the importance of statin use for cardiovascular risk reduction and formulary medication options.

Maternal Child Health

Prenatal and Postpartum Care Services (PPC)

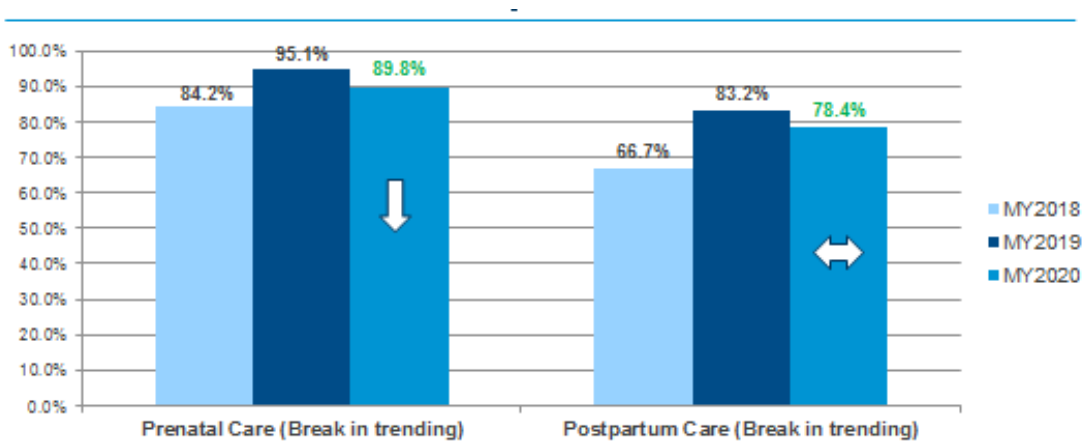
The hybrid HEDIS and MCAS measure, PPC, measures the percentage of deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that 1)

received a prenatal care visit in the first trimester and 2) obtained a postpartum care visit on or between 7 and 84 days (1–12 weeks after delivery).

The figure below shows the trend analysis for the Medi-Cal PPC measure for MY2018–20. The Prenatal and Postpartum Care measure both met the 33rd percentile for MPL and the organization's percentile goal. While the Prenatal Care measure met the MPL, the final percentile was statistically lower than MY2019.

Figure 1: PPC HEDIS Rates MY 2018–20

HEDIS MY 2020 Results: Medi-Cal Prenatal and Postpartum Care

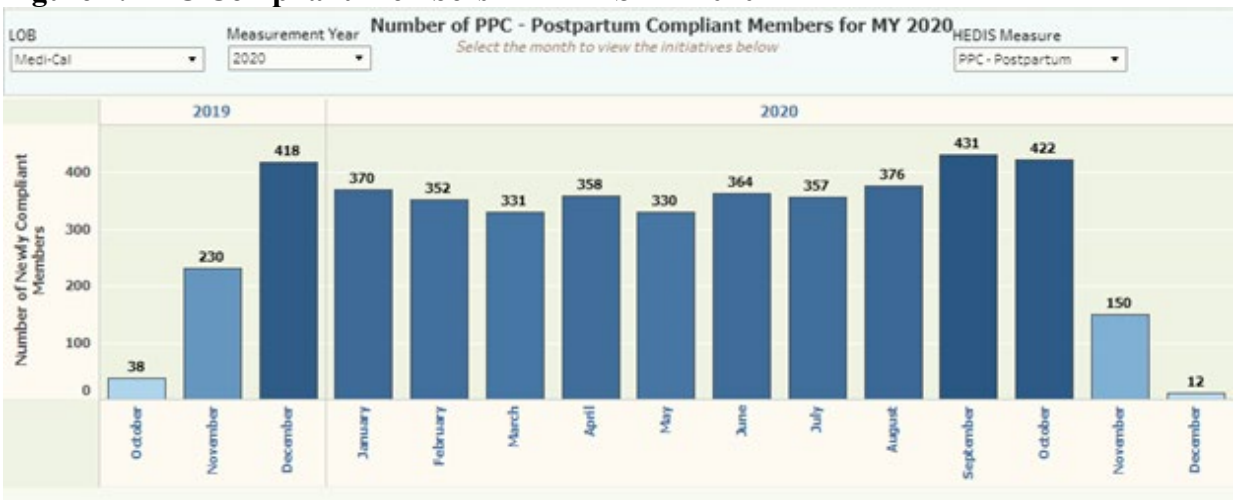


HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	86.86%	91.73%	95.86%	89.05%	HPR, MPL, P4V
Postpartum Care	73.72%	79.32%	84.18%	76.40%	HPR, MPL, P4V

**Red is less than 33rd percentile; Green is met the goal; Purple is MPL met, ++measure triple weighted for Health Plan Ratings*
*↓↑ statistically higher or lower ↔ statistically no difference ** HPR is Health Plan Ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

Figure 2 below represents all Medi-Cal members with live births between October 8, 2019, and October 7, 2020, that met the continuous enrollment criteria and were compliant with the HEDIS measure.

Figure 2: PPC Compliant Members in HEDIS MY2020



Note: The table does not include Kaiser members as they are not outreached for quality initiatives

Table 1: List of 2020 PPC Initiatives

The PPC initiatives listed correspond to the 2020 calendar year from January 1 through December 31. The PPC HEDIS measures births between 10/8/2019–10/7/2020 that were compliant with a postpartum visit between 10/15/2019–12/31/2020 (1–12 weeks after delivery). The initiatives noted with an asterisk * were offered between 10/15/2019–12/31/2019.

Initiative	Start Date	End Date	Outreach Population	Description
Member Health Reward*	1/1/2020	12/31/2020	425	$50 member reward for completing a postpartum visit 1–12 weeks after delivery
Member Outreach*	1/1/2020	12/31/2020	2,421	Bright Steps program for moms and babies
P4V*	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Summer 2020 Medi-Cal Newsletter	7/13/2020	7/16/2020	HOH: 454,854	Medical newsletter targeting prenatal and postpartum health: • Article highlighting maternal mental health • Call out in "New Members Start Here" to encourage prenatal care • 2020 CalOptima Health Rewards highlighting the postpartum reward
Website*	1/1/2020	12/31/2020	All, public	Promotion of member health reward forms and Bright Steps program
Social Media	6/24/2020	6/24/2020	All, public	Telehealth and prenatal care video

Table 2 examines compliance with the postpartum measure (PPC) for the top 10 race/ethnicities by denominator. The lowest rate with substantial members is for White members (64.18%). Member who did not provide race/ethnicity information is among the groups with the highest rates of

compliance with 70%, followed by Vietnamese members (82.30%).Table 3 examines PPC rates by member written language. The highest rate of compliance is among Vietnamese members (83.04%), although this group only represents close to 5% of the total denominator (7,223). The lowest rate is English (68.23%); however, this group represents 55% of the total denominator.

Table 2: Medi-Cal PPC HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	No Response	White	Vietna-mese	Other	Black	Filipino	Korean	Asian or Pacific Islander	Asian Indian
Numerator	2,799	793	593	386	179	85	55	44	38	19
Denominator	3,992	1,133	924	469	253	133	77	60	57	25
Rate	70.11%	70%	64.18%	82.30%	70.75%	63.91%	71.43%	73.33%	66.67%	76%

Note: Includes Kaiser members

Table 3: Medi-Cal PPC HEDIS MY2020 Rates by Threshold Language

Admin	Languages					
HEDIS MY2020	English	Spanish	Vietnamese	Farsi	Arabic	Korean
Numerator	3,617	1,039	284	20	35	20
Denominator	5,301	1,406	342	26	51	26
Rate	68.23%	73.90%	83.04%	76.92%	68.63%	76.92%

Note: Based on written member language preference; includes Kaiser members

2020 Prenatal and Postpartum Initiatives: Medi-Cal

1. Intervention: Bright Steps Program (BSP)

A. Description

Bright Steps is a CalOptima program for prenatal and postpartum Medi-Cal members. The program offers education, educational materials, resources and support for mom and baby through trimester and postpartum phone calls. BSP was launched in September 2018. Since its inception, the outreach to pregnant and postpartum mothers has continued to grow each measure year. The data presented in this report is not reflective of the vast program outreach and member engagement efforts as not all members that are compliant with the PPC HEDIS measure take part in BSP.

B. Reporting

In March 2020, BSP launched new CORE report, CC0226, to document member outreach attempts and engagement throughout trimester and postpartum calls. In the previous process, BSP did not count on sophisticated reporting and only had the ability to identify the outreach efforts made by program staff. Consequently, when identifying member participation efforts for purposes of this report, there are differences as true engagement prior to March 2020 was not able to be measured.

C. Findings

PPC Table 4. BSP Engagement — MY2019 and MY2020

HEDIS MY	BSP Participation Includes Members Non-Compliant with PPC Measure	HEDIS Denominator	BSP Participation Rate
2019	631	**6,628**	9.52%
2020	787	**7,223**	10.90%

PPC Table 5. Postpartum Compliance and Postpartum Member Health Reward Participation Among Members that Completed a BSP Postpartum Assessment — MY2020

HEDIS MY	Members that Completed a BSP Postpartum Assessment	Members Compliant with Postpartum Visit	Health Reward Participation
2020	664	519 519/664 (78.16%)	126 126/664 (18.98%)

PPC Table 6. PPC Compliance Among BSP Participants

HEDIS MY 2020				
Variables	Total	Denominator (BSP Participants)	MY2020 Rate	MY2019 Rate
BSP participants compliant with PPC HEDIS measure	605	787	605/787 (76.87%)	74.96%
BSP participants not compliant with PPC HEDIS measure	182	787	182/787 (23.13%)	25.04%

D. Analysis

1. In MY2020, 76.87% of BSP participants were compliant with the PPC HEDIS measure. This suggests that BSP participation is associated with an increased likelihood of being compliant with the PPC HEDIS measure.
2. Compared with MY2019, there was a slight increase (1.91%) of PPC compliance among members that participated in BSP.
3. There was an increase in outreach efforts to engage members in BSP. In MY2019, BSP outreached to 2008 members. In turn, during MY2020, BSP outreached to a total of 2,421 members, up 20.57%. While outreach efforts increased, there was only a 1.38% increase in actual BSP participation.
4. PPC compliance was assessed among all BSP participants. Completion of a postpartum assessment with BSP was associated with being compliant with a postpartum visit. (Refer to Table 6)
5. Postpartum member health reward participation among members that completed a Bright Steps postpartum assessment was less than 20%. This suggests that members who are achieving the postpartum measure compliance may be opting not to participate in the reward program or the postpartum member health reward may not be a contributing factor to measure compliance.

D. Barriers

1. Concerns about maternal and newborn safety during COVID-19 may have contributed to limited or reduced provider visits and reduced provider promotion of CalOptima's BSP.
2. The pandemic exacerbated the social and economic challenges already faced by the vulnerable population we serve. Subsequently, the pandemic may have contributed to a rise in competing priorities for our membership base, which may have limited the participation in this program.
3. COVID-19 changed the health environment. The pandemic placed expectant members at higher risk of potential complications from the virus. It impacted the way providers were able to deliver care to members and how members accessed prenatal care.
4. The PPC HEDIS measure changed to allow telehealth for prenatal and postpartum visits. While this improves access for some segments of the population, telehealth also presents barriers for segments of the population with low or limited technical literacy.
5. The COVID-19 pandemic has highlighted social inequities and negative experiences that create a challenging environment for expectant mothers. Barriers such as limited or no income, limited ability to afford transportation to and from medical appointments, lack of childcare support, among others creates conditions where it is difficult to access prenatal programs and care or access it in a timely manner.
6. BSP outreach is predominantly driven by a pregnancy notification report (PNR) to CalOptima. No notification results in a missed opportunity for outreach and program engagement.
7. Similarly, a late pregnancy notification results in a missed opportunity to provide support and critical information early in the member's pregnancy. COVID-19 may have contributed to instances where members sought care in later stages of their pregnancy, thus impacting the timeline in which a PNR was received, and outreach initiated.
8. BSP engages only a small portion of the HEDIS denominator. Engagement in the Bright Steps and Postpartum member health reward have increased, but overall participation rates remain low among members compliant with the PPC HEDIS measure indicating that members may not be aware of or may not be taking advantage of these programs. Limited participation creates challenges in identifying the impact of these programs on PPC HEDIS measure compliance.

E. Opportunities for Improvement

1. Identify ways to increase member awareness and augment Bright Steps program participation. Strategies may include increasing PNR submissions and, improving the timeliness of PNR submissions.
    a. During 2021, efforts have gone underway to augment awareness of Bright Steps, PNRs, provide Bright Steps fliers and brochures to OB provider offices.
2. COVID-19 has not only exacerbated inequities that are intertwined with negative health outcomes, but the pandemic also imposed long-term effects on health care systems. Continuing to offer BSP will support the promotion of healthy pregnancies and babies during a time where it is evident that there is an increased need for flexibility in the delivery mode of health services and to remediate the effects of the pandemic.
3. Create awareness campaigns that target members that are at higher risk of maternal health complications due to inequities associated with demographic factors such as age, race/ethnicity.

4. Continue BSP promotion efforts among, health networks, providers and community organizations by leveraging the existing communication avenues such as: Provider Update, Health Network Weekly Communication, Health Network quality meetings, and information sharing through community collaboratives focused on maternal health.
5. Augmenting CalOptima's website to have a dedicated webpage with information that supports the various prenatal stages and available in the Medi-Cal threshold languages. The Bright Steps program booklet and CalOptima's Instagram, Facebook and Twitter media pages can be leveraged to drive webpage promotion and user traffic.
6. Shift to a multilayered outreach approach that targets members, providers, the community partners and health care partners. Approach should include community events that address the needs within the environment and enable the delivery of education and health care services where members reside. Community events also provide an opportunity for members to have a positive member experience with their health plan.
7. Research suggests that access to insurance alone will not remove barriers to care. Further assessment among noncompliant members is necessary to better understand the barriers to postpartum care and implement strategies to reduce those barriers. Additional opportunities to understanding challenges from member's point of view may include conducting outreach by mail, supplemented with telephonic outreach or conducting electronic/online surveys.

2. Intervention: Postpartum Checkup Member Health Reward MY2019–20

A. Description

The Postpartum Checkup Member Health Reward Program is a member health reward program that provides $50 to members who gave birth between October 8, 2019, and October 7, 2020, and complete a postpartum visit between 1–12 weeks after delivery.

B. Findings

The table below shows the participation rates in the Postpartum Checkup Incentive Program. Participation rates have increased since the program start in September 2018. The MY2020 participation rate represents a 4.14% increase from the previous measure year.

PPC Table 3. Postpartum Checkup Member Health Reward Submissions MY2020

HEDIS MY	PPC Incentive Submissions	PPC Measure Denominator (Total births)	Response Rate
2020	425	7,223	**(425/7,223) 5.88%**

PPC Table 5. PPC Incentive Submissions by Members Compliant with MY2020

HEDIS MY	Members in Compliance with PPC Measure that Participated in PPC Incentive	Total Members in Compliance with PPC Measure	PPC Incentives Submitted by Members Compliant with PPC Measure
2018	56	3,954	**(56/3,954) 1.41%**
2019	102	4,743	**(102/4,743) 2.15%**
2020	396	5,060	**(396/5,060) 7.82%**

The table below indicates the cities with the highest percentage of members who are not compliant with postpartum care within the recommended timeframe. A total of 2,163 members were not compliant with the PPC HEDIS postpartum measure.

PPC Table 6. Members Non-Compliant with Postpartum Care MY2020

City	Total Members Non-Compliant with Postpartum Visit	Total Percent Non-Compliant with Postpartum Visit
Garden Grove	164	**(164/2,163) 7.58%**
Santa Ana	418	**(418/2,163) 19.33%**
Anaheim	429	**(429/2,163) 19.83%**

C. Analysis

1. Participation in the Postpartum Member Health Reward program during 2020 has increased by 5.67% from 2019.
2. When assessing health reward participation among members compliant with the postpartum visit (n=5060), 7.82% of members engaged in the reward program indicating that most members in compliance are not aware of this program or are not taking advantage of it.
3. Participation in the reward program was highest among Hispanic members (68.71%). On the contrary, program participation among other ethnic groups was low: Black (0.47%), White (7.53%) and Asian (7.53%). Note, the Asian ethnic group aggregates members who identify as Asian Indian, Asian or Pacific Islander, Filipino, Cambodian, Vietnamese, Chinese and Korean.
4. There are varying timeframes for completing the recommended postpartum visit. Most members (36.67%) are completing a postpartum visit between 3–4 weeks after delivery. Less than 5% of compliant members are getting a postpartum visit after 9 weeks indicating that providers are making efforts to complete visits earlier.
5. Members between the ages 18–29 were the age group most non-compliant with postpartum care representing 61.63% of the non-compliant cases.
6. Santa Ana (19.33%) and Anaheim (19.83%) represent the two cities with the highest rates of members who are non-compliant with postpartum care 1–12 weeks after delivery.
7. When it comes to postpartum care, disparities exist between racial/ethnic groups. Hispanic women represent the highest percentage (55.10%) of members who are not compliant with care.
8. Hispanic women account for 46.96% of the births in MY2020, however, almost one third of those births are not compliant with a postpartum visit (29.86%).
9. Black women account for <2% of the births. Of those births among Black women, more than one-third (35.82%) are not complaint with postpartum care.
10. Compliance with prenatal care visits was associated with increased likelihood of compliance with a postpartum care visit.

D. Barriers

1. The COVID-19 pandemic may have changed the way members accessed postpartum care. Concerns about maternal and newborn safety during COVID-19 contributed to limited or reduced provider visits and may have reduced the promotion of CalOptima's Postpartum Checkup Incentive Program.

2. Increase in COVID-19 transmissions and a statewide lockdown mandate during the MY2020 may have been contributing factors for noncompliance with postpartum visits.
3. PPC HEDIS measure changed to allow telehealth for postpartum visits. While this improves access for some segments of the population, telehealth also presents barriers for segments of the population with no or limited access to reliable internet as well as those with low or limited technical literacy.
4. BSP outreach during the postpartum period is predominantly driven by a pregnancy notification report (PNR) to CalOptima. No notification results in a missed opportunity for outreach at the postpartum timeframe.
5. The Postpartum member health reward effort engages only a small portion of the HEDIS denominator (5.88%). Most members that do engage in PCIP are compliant with the postpartum measure (93.18%).
6. Engagement in the Bright Steps and health rewards have increased, but overall participation rates remain low among members compliant with the PPC HEDIS measure indicating that members may not be aware of or may not be taking advantage of these programs. Similarly, limited participation creates challenges in identifying the impact of these programs on PPC HEDIS measure compliance.

E. Opportunities for Improvement

1. While most members are compliant with the postpartum visit and do not take advantage of the health rewards program, this suggests that there is a need continue to promote the health rewards through the available platforms (member newsletters, CalOptima website, provide offices, etc.). It is an opportunity to engage those members who are not compliant.
2. Improved data sharing with CalOptima providers may increase PNR rates and augment outreach efforts to enroll members in health rewards and BSP.
3. Augment the promotion avenues of health rewards. Additional channels may include direct mailings, targeted social media campaigns, IVR calls, mobile text messages and leverage existing health network quality meetings to enhance collaborative efforts.
4. To maximize outreach efforts, consider targeted messaging to focus on the 18–29 age group and regions where members with the highest non-compliance rates reside. In addition, increase targeted messaging to Hispanic members that represent more than half of the rates of non-compliance.
5. Continue to leverage BSP to help close gaps in care.
6. To support a continuum of care all the way through the postpartum period, there is a need to implement or enhance strategies that focus on ensuring timely prenatal care. Need to continue to drive PNR completion among providers.
7. Augment community partnerships with organizations that work with our membership base to increase program awareness.

Additional PPC Activities in 2020

1. CalOptima-sponsored Facebook, Twitter and Instagram posts related to telehealth and prenatal care.
2. Presentations at community-based organizations.
3. Promotion of Bright Steps across seven WIC offices. BSP posters were provided to OCHCA WIC offices.

Additional PPC Activities in 2021

This activity list is based on the 2021 (January 1 through December 31) calendar year. MY2021 for PPC postpartum runs on a different timeline, as it is looking for postpartum compliance between October 15, 2020, to December 31, 2021 (1–12 weeks after delivery). The initiatives noted with an asterisk * were offered between 10/15/2020–12/31/2020.

Table 7: List of 2021 PPC Initiatives

Initiative	Start Date	End Date	Description
Member Health Reward*	1/1/2021	12/31/2021	$50 member reward for completing a postpartum visit 1-12 weeks after delivery
Member Outreach*	1/1/2021	12/31/2021	Bright Steps program for moms and babies
P4V*	1/1/2021	12/31/2021	Pay 4 Value program
Spring 2021 Medi-Cal Newsletter	March 2021	March 2021	Medical newsletter targeting prenatal and postpartum health: • Article highlighting importance of prenatal care • Call out in "New Members Start Here" to encourage prenatal care
Website*	1/1/2021	12/31/2021	Promotion of member health reward forms and Bright Steps program
Social Media	1/1/2021	12/31/2021	Facebook, Twitter and Instagram posts related to prenatal and postpartum health
CalOptima Diaper Days	Quarterly	Quarterly	Community events that provide OC families with diapers, education and access to resources. Events will target areas where our pregnant and recently delivered moms live
OB Provider PPC Mailings	06/23/2021	06/23/2021	PPC mailings to OB provider offices with information on Bright Steps, PNRs, Postpartum Member Health Reward Forms
PPC Provider Fax Blast	07/2021	07/2021	Provider fax blast emphasizing message to OB providers on PPC program and information shared in the PPC mailings
Targeted social media promotional campaigns *(new)*	TBD	TBD	Leveraging geomapping to identify areas of low compliance for targeted advertisement campaigns

Pediatric/Adolescent Wellness

Well-Child Visits in the First 30 Months of Life (W30)

In October 2020, Well-Child Visits in the First 15 Months of Life (W15) was retired and revised to Well-Child Visits in the First 30 Months on Life (W30). The HEDIS and MCAS W30 measure reports two rates: (1) Well-Child Visits in the First 15 Months and (2) Well-Child Visits for Age 15

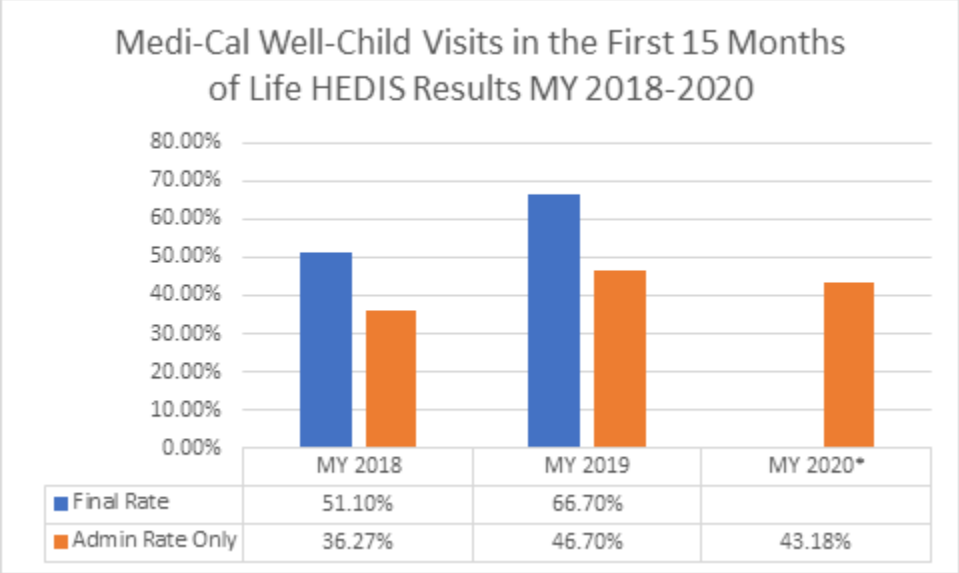
Months–30 Months. Well-child visits continued to be a top priority for CalOptima during 2020. The focus was on increasing compliance for the sub-measure, which requires the completion of six well-child visits for members from birth to before their 15-month birthday.

Performance Against Goal:
There are no benchmarks for comparison of the W30 measure since it's treated as a first-year measure. The W15 measure met the MPL for MY 2019. CalOptima proactively monitored prospective rates on a monthly basis and ensured active trend analysis for outliers. In Table 1 below, the final W30 HEDIS rates for MY 2020 are identified. Furthermore, Figure 1 provides an overview of pediatric well-child visit trends from MY 2018 to MY 2020. Please note W30 First 15 Months HEDIS measure was pulled in place of W15 to evaluate MY2020.

W15 Table 1: Well-Child Visits in the First 30 Months of Life (W30) Final HEDIS 2020 Rate

Well-Child Visits in the First 30 Months of Life (W30)	Rate
Well-Child Visits in the First 30 Months of Life (First 15 Months)	43.18%
Well-Child Visits in the First 30 Months of Life (15 Months–30 Months)	71.76%

W15 Figure 1: Final HEDIS Rates for Well-Child Visits in the First 15 Months of Life 2018–20



W15 measure specifications were used to identify MY2018–19 final HEDIS rates.
**MY2020 administrative rate is based on W30-First 15 Months measure.*

W15 Figure 2: Number of Members Compliant for W15 (Well-Child 6+ Visits) for MY2020

W15 Figure 2 represents all new compliant (six or more visits by 15 months) members by month between March 2019 and December 2020 ($n_{outreached}$=3531) for MY2020. These members fall in the HEDIS 2020 ***W30-First 15 Months*** *denominator (N=8,669). The* ***W30-First 15 Months*** *administrative rate is 43.18%. *Note, Kaiser members are excluded from this data set since they are not outreached for initiatives. Numerator reflected here is lower than final administrative rate numerator (n_{actual}=3,743).*

W15 Table 2: Well-Child Visits in the First 15 Months Initiatives in 2020

Initiative	Start Date	End Date	Outreach Population	Description
Well-Child Visits 1–3 Member and Provider Incentive Program	1/1/2020	12/31/2020	1,674 members approved	Member and provider incentive program for completing 1st, 2nd and 3rd well-child visits. Members received a $50 gift card. Providers receive a $50 check.
Well-Child Visits 4–6 Member and Provider Incentive Program	1/1/2020	12/31/2020	793 members approved	Member and provider incentive program for completing 4th, 5th and 6th well-child visits. Members received a $50 gift card. Providers receive a $50 check.
Posted incentive forms on website	3/1/2020	12/31/2020	All, Public	Well-Child Visits 1–3 promoted on Health Rewards Program landing page.
Posted incentive forms on website	3/1/2020	12/31/2020	All, Public	Well-Child Visits 4–6 promoted on Health Rewards Program landing page.
CalOptima Days - W15 Only (CHOC Health Alliance)	3/4/2020	3/5/2020	125 eligible CalOptima Medi-Cal members	A collaboration with CHOC Health Alliance to host a health and wellness event focused on children and adolescents due for W15, W34 and All Well Child (AWC).
Spring 2020 Medi-Cal Newsletter	3/19/2020	3/19/2020	HOH: 441,196 Medi-Cal Members	Newsletter included articles on: (1) Stay Well, Play Well ad. (2) Well-Child Visits, getting well-child visits are a key part of your child's health. (3) Infant and Child Car Seat Safety
Provider Fax Blast: Well-Child Visits During COVID-19 Pandemic	5/20/2020	5/20/2020	All health networks and CCN providers	Well-Child Visits During the COVID-19 article was included in the Provider Update via fax blast.

Provider Fax Blast: 2020 CalOptima Member and Provider Incentive Programs	7/20/2020	7/20/2020	All health networks and CCN providers	CalOptima Member and Provider Incentive Programs article was included in the Provider Update via fax blast.
Health Guide 0–2 Newsletter + W15 Incentive Mailing	7/24/2020	7/24/2020	8,960 Medi-Cal members	Newsletter mailing discussing the importance of well-child visits, vaccinations, developmental milestones and healthy eating and the Well-Child Health Rewards was mailed to 0–12 months old Medi-Cal members.
Post Bright Steps Well-Baby Follow-Up Calls	9/8/2020	Ongoing	160 Parent or Guardian were Outreached	Outreach calls to mothers who participated in Bright Steps Program to follow up on their newborn(s) to complete well-child assessment.
Social Media Posting	8/19/2020	8/19/2020	All, public	Social media post about: Don't delay your child's checkup and immunizations (Instagram, Facebook, Twitter)

2020 Well-Child Visits in the First 15 Months Initiatives: Medi-Cal

1. Intervention: Well-Child Visits 1–3 and 4–6 Member Health Reward Program (1/1/2020-12/31/2020)

A. Description: This member health reward program consisted of identifying CalOptima Medi-Cal members ages 0–15 months due for Well-Child Visits 1–3 and 4–6. The health reward was approved if eligible members completed three or six well-child visits before turning 6 months or by the 15-month birthday, respectively. A form was completed by the provider and faxed in to CalOptima within 60 days of the third or sixth date of service (DOS). The health reward program launched on January 1, 2020, and ran through December 31, 2020. Member submissions that were approved received a $50 gift card via mail. The reward participation rate was tracked utilizing the PHM Incentive database.

B. Findings

W15 Table 3: Total W15 Member Health Reward Participation Rates

Well-Child Health Reward Program	Forms Received	HEDIS Qualified	HEDIS Denominator	Health Reward Participation Rate
1–3 Visits	1,796	284	8,669	3.28%
4–6 Visits	867	515	8,669	5.94%

Data source from PHM Incentive database and final HEDIS 2020 rates

W15 Table 4: Members Participation in W15 1–3 Health Reward by Written Language

Member Written Language	Count of Member Submissions for W15 1–3 Health Reward	% of Total Submissions
English	182	64.08%
Farsi	2	0.70%
Spanish	91	32.04%
Vietnamese	9	3.17%
Grand Total	**284**	

W15 Table 5 Members Participation in W15 4–6 Health Reward by Written Language

Member Written Language	Count of Member Submissions for W15 4–6 Health Reward	% of Total Submissions
Arabic	1	0.19%
English	295	57.28%
Farsi	3	0.58%
Korean	3	0.58%
Spanish	172	33.40%
Vietnamese	41	7.96%
Grand Total	**515**	

C. Analysis

1. There was a total of 2,663 W15 1–3 and W15 4–6 member reward forms received. Of those, 765 unique members fell in the W15 denominator.
2. Only 34 members participated in both W15 1–3 and W15 4–6 Member Health Reward Program who fell into the W15 denominator. Of those only 24 are compliant for W15.
3. Total member reward expenditures = (1674+793) x $50 = $123,350.
4. Members participated in the W15 1–3 Health Reward 1.07 times more than the W15 4–6 Health Reward Program.
5. As identified in Table 2, the impact on HEDIS for this reward participation rate is low, 3.28% and 5.94% for Well-Child Visits 1–3 and 4–6, respectively. Health Reward participation rate is calculated by 'HEDIS Qualified' divided by 'HEDIS Denominator'.
6. As identified in Table 3 and 4, the reward participation by member's written language. Majority of members preferred written language is English (64.08% and 57.28%) and Spanish (32.04% and 33.40%) for W15 1–3 and W15 4–6 reward respectively.

D. Barriers

1. Only those members turning 15 months old in the measurement year technically fell into the HEDIS measure. Therefore, members who were too young may have completed six visits but are not counted toward W15 denominator until the year after.
2. Since the submissions were not validated against claims and encounter data, the third and/or sixth DOS was not validated. Reward forms were taken at face value.
3. Anecdotal qualitative data showed that in clarification inquiries with various provider offices, certain members were unable to complete their sixth W15 visit before their 15-month birthday, because providers were routinely scheduling members after the member turned 15 months.
4. The COVID-19 pandemic impacted preventative well-care visits. Provider offices were not scheduling well-child visits at the peak of the pandemic, further exacerbated by office closures in Spring 2020. When offices reopened scheduling was split and reduced to safeguard patients and staff. Providers are hesitant to perform well-care visits via telehealth since infant cannot speak for themselves.

E. Opportunities for Improvement

1. For future iterations, revise reward program to require all 6 visits versus breaking the visits into two separate rewards. Despite there being more W15 1–3 forms submitted (by 1.07 times) than W15 4–6, it did not drive compliance.
2. Provide clearer instructions of the measure requirements of when the sixth visit is to be completed.
3. Since the well-child measure is based on a series of visits, should aim to work closely with providers to make an impact rather than outreaching to members.

2. Intervention: Well-Child Visits 1–3 and 4–6 Provider Incentive Program (1/1/2020–12/31/2020)

A. Description

Incentive program was made available to all providers who served CalOptima Medi-Cal members ages 0–15 months old. This incentive aligns with the member incentive as it requires the provider to attest to the visits and fax the form within 60 days to CalOptima. For Well-Child Visits 1–3 and 4–6 incentive, they must complete three or six well-child visits before turning 6 months or by the 15-month birthday, respectively. The incentive program launched January 1, 2020 and ran through December 31, 2020. Submissions were validated by claims data. Providers were given a $50 incentive per each approved submission. The following evaluation is data is from PHM Incentives database and final HEDIS 2020 rates.

B. Findings

1. Total of 2,663 submissions were entered into the database.
2. 2,020 out of 2,663 submissions were processed for provider incentive payment.
3. 643 submissions were not processed for Quarter 4 or retrospective payment.
4. Limitations: if a provider submitted an incentive form late, but for a DOS for another an earlier quarter it may have not been processed. Forms were processed by quarter in which the 3rd or 6th DOS fell in.
5. 85 unique providers or offices by Tax Identification Number participated in the well-child provider incentive program.

W15 Table 6: Summary of Well-Child Provider Incentive 2020

Incentive Program	Total Submissions	Total Approved	Total Denied	Not Processed	Total Incentive
Well-Child 1–3 Visit	1,796	1,151	234	411	$57,550
Well-Child 4–6 Visit	867	468	167	232	$23,400
Totals	2,663	1,619	401	643	$80,950

W15 Table 6, approved submissions were validated by claims and encounter data. Total denied is defined as record was processed and assessed for payment yet did not meet the criteria to be incentivized. Not processed indicates records submitted but not processed for provider payment. Note, members, if approved, were awarded a $50 gift card.

C. Analysis

1. Of the 1,619 approved submissions, 410 members were compliant for W15 by the end of the measure period.
2. 1,619 submissions were approved for a provider incentive. However, only 557 members whose form was received fell into the denominator (410 were compliant for W15).

D. Barriers

1. Provider participation exceeded expectations. Budget was not adequate to complete provider incentive payments for Quarter 4, 2020.
2. 643 submissions were not processed for provider payment due to budgetary constraints. Approximately 494 of these records would have been approved for payment ($24,700).
3. It is probable the sixth DOS submitted are accurate and claims and encounters were received but was rejected since it did not meet all the W15 HEDIS specifications to be a numerator hit.

E. Opportunities for Improvement

1. For future provider incentive programs, improvement of communication and promotion of incentives to include language about program limitations and that offering can be discontinued at any time without prior notification by CalOptima is necessary.
2. Consider outreaching to provider offices with a large volume of W15 members that are low performing to collaborate on an improvement project.
3. Work closely with health networks to identify which offices may need help understanding HEDIS metrics.
4. Modify the provider incentive program to be available to a selected a few offices who have potential of making a big impact on the well-child rate and do a tiered payment system versus payment per member to alleviate budgetary constraints.

3. Intervention: CalOptima Days at CHOC Health Alliance Sites (3/4/2020–3/5/2020)

A. Description

There was a concerted effort to increase the number of W15 visits starting in April 2019. CalOptima's collaboration with CHOC Health Alliance to host wellness events at CHOC Orange Clinic and Clinica CHOC Para Ninos were held in March 2020. The clinics focused on outreaching and scheduling members due for W15, W34 or AWC. The incentive was based on a payment tier with a base pay for holding an event for $500 and maximum incentive of $2,500, yielding $3,000 total.

B. Findings

1. CHOC Orange Clinic had two event days, 114 appointments were scheduled, 103 attendees and 80 confirmed CalOptima Medi-Cal members.
2. Clinica CHOC Para Ninos had two event days, 82 appointments were scheduled, 64 attendees and 45 confirmed CalOptima Medi-Cal members.

W15 Table 7: CHOC Health Alliance CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed Eligible Members	Incentive Amount
CHOC Orange Clinic	114	103	90.35%	80	$3,000
Clinica CHOC Para Ninos	82	64	78.05%	45	$3,000

C. Analysis

1. A total of $9,000 was incentivized to CHOC Health Alliance for hosting the CalOptima Day events and 125 eligible CalOptima Medi-Cal members were seen.
2. CHOC Health Alliance experienced a high attendance rate 78.05%–90.35%.
3. Only 36 members fell in the W15 denominator and six members' visit yielded a numerator hit.

D. Barriers

1. Coordinating events with participating provider clinics.
2. Challenges outreaching to members to attend the clinics with only the W15 population to contact.
3. Difficulty obtaining the event schedule list (participant list) from the sites post event.

E. Opportunities for Improvement

1. Establishing clear expectations in engaging in such events may eliminate communication and delays in execution.
2. Complete a robust analysis of clinic's pediatric population to identify a larger outreach population for scheduling for future events. This may include multiple measures and age groups.

4. Intervention: Health Guide 0–2 Newsletter and Well-Child Incentive Mailing (7/24/2020)

A. Description: Health Guide Newsletter includes health education content specifically for the 0–2 years old age range. The Well-Child Visits 1–3 and/or 4–6 incentive forms were included in the mailings for eligible members. Mailings were sent on July 24, 2020, targeting 8,690 CalOptima Medi-Cal members.

B. Findings

1. 2,944 out of the 8,690 members who were mailed the newsletter and incentive form fell in the W15 denominator.

C. Analysis

1. 563 members completed their sixth well-child visit DOS after receiving the mailing.
2. 35 members in this targeted mailing submitted the W15 4–6 incentive form and were compliant for W15.

D. Barriers

1. No barriers.

E. Opportunities for Improvement

1. Expand Health Guide Newsletter distribution through digital options.
2. Distribute Health Guides as supplemental education source for members and providers.

5. Intervention: Post Bright Steps Well-Baby Follow-Up Call Initiative (9/9/2020–Ongoing)

A. Description

A collaborative effort with health education team was made to outreach to members who completed their Postpartum Assessment by participating in BSP. In leveraging BSP participants, health educators were able to connect with the parent of newborn members and follow-up on their well-care visit status. Calls began September 9, 2020, and this is a continued effort.

B. Findings

1. 191 Post Bright Steps Well Baby Follow-Up call scripts were created between 9/9/20–12/31/20.
2. 160 calls were made to unique Medi-Cal members who participated in the BSP.
3. 112 call scripts were completed and successful. Call success is defined as the health educator was able to reach a live person and conduct the call script. Note: some members were outreached more than once if they were identified as a high priority member or had more than one birth recently (e.g., twins).
4. No members who participated in the Post Bright Steps Well-Baby Follow-Up Call Initiative fell in the W15 denominator for MY 2020.

C. Analysis

1. The outbound call initiative began in September 2020 to newborn members. A majority of members fell in the W30 First 15 Months denominator for MY2021 instead of impacting MY2020.

D. Barriers

1. Pediatric well-child visits measure date of births span over a longer time period than the actual measurement year. For W30 First 15 Months, the member must turn 15 months in the measurement year. To evaluate outreach data will be available a year later.
2. Outreach is limited since it only reaches those whose parent participated in the BSP and continued to be a CalOptima Medi-Cal member on date of outreach.

E. Opportunities for Improvement

1. If data shows positive impact on child's health, consider adding an additional outreach when member is 12 months old to connect BSP aims with child wellness to 1) reaffirm child is on track for well-child visits and vaccinations, and 2) discuss family planning with mother.

2. Collaborate with Maternal Health Team who oversees BSP to complete a robust data analysis including member demographics between BSP participation and general CalOptima membership (pregnant women) to see if their child has better health outcomes. Additionally, to leverage this information to build promotional campaigns and target subcommunities where this resource (BSP) can make a positive health impact.

Additional Well-Child Visits in the First 15 Months Activities in 2020:

1. Well-Child Visits 1–3 and 4–5 Incentive forms were posted to CalOptima's Health Rewards Program landing page (3/1/20–12/31/20).
2. Medi-Cal 2020 Spring Newsletter Mailing (3/19/2020). Newsletter included the following, (1) Stay Well, Play Well advertisement, (2) Well-Child Visits, Getting Well-Child Visits Are A Key Part of Your Child's Health, and (3) Infant and Child Car Seat Safety article. The member newsletter was mailed to 441,196 head of household Medi-Cal members.
3. Provider Fax Blast: Well-Child Visits During COVID-19 Pandemic (5/20/2020). An article was included in Provider Update. The fax went to all contracted providers.
4. July 2020 Community Connections Newsletter included the promotion of all Health Guide Newsletters (0–2 years, 3–6 years, 7–12 years, 13–17 years and 18–21 years old). Communication went out to all newsletter subscribers on 7/15/2020. Community Connections has more than 2,700 readers, representing local community-based organizations, non-profits, charities, local agencies, providers and entities.
5. Provider Fax Blast: 2020 CalOptima Member and Provider Incentive Programs (7/20/2020). An article was included in Provider Update Newsletter. The fax went to all contracted providers.
6. *Stay Current On Well-Care Visits, Screenings and Immunizations* social media was posted to Facebook (engagement rate 15/195 = 7.9%), Instagram (engagement rate 6/190 = 3.1%), and Twitter (engagement data N/A) (8/25/20).

2021 Well-Child Visits in the First 15 Months Initiatives: Medi-Cal

1. Well-Child Visits, 0–30 Months text message campaign, planned for Q4 2021.
2. Medi-Cal 2021 Summer Newsletter Mailing (7/06/2021). Newsletter included *During the COVID-19 Pandemic Is It Safe for Well-Care Visits* article. The member newsletter was mailed to 514,256 head of household Medi-Cal members.

F. Opportunities for Improvement:

1. Conduct a formal evaluation of how data gaps can be closed, since W15 measure is revised to W30 and will strictly be an administrative measure.
2. Promote well-child visits through BSP prenatal and postpartum calls and through Post Bright Steps Well Baby Follow Up Call Initiative.
3. Leverage BSP educational member booklet which includes well-child visits and vaccination schedule to help parents keep on track with their child's health (e.g., vaccine passport they can put on their refrigerator).
4. Since the COVID-19 pandemic impacted health care in 2020 and the W30 population spans over calendar years, impact on the rate may be delayed. Need to continue to closely monitor population for any significant changes.

5. Continue to collaborate and grow partnerships with community-based organizations (e.g., AAP) to develop and/or align with campaigns to further promote the importance of well-care visits and vaccinations.
6. Table 8 below examines the ethnicity breakdown of subpopulations within the W30 First 15 Months measure. This new approach to data pulls will allow the opportunity to address social determinants of health and understand inequities in health care. There is a large Black population of membership, but their W30 First 15 Months rate is lower than other highly populated groups. Future efforts should include identifying subpopulations and their barriers to better focus efforts where needed.
7. In addition to completing outreach in member's threshold language, outreach campaigns should be tailored to subpopulations in various modalities (e.g., text message, radio advertisement, newspaper advertisement, mailing, social media) and culturally appropriate.

W15 Table 8: HEDIS 2020 W30 First 15 Months Rate by Member Ethnicity, 10 Highest Volume Groups

Ethnicity	W30 First 15 Months Numerator Rate	Numerator Count	Denominator Count	Percentage of Total Population	Impact on HEDIS Rate
Hispanic	43.82%	2,092	4,774	55.07%	24.13%
No response, client declined to state	41.43%	563	1,359	15.68%	6.49%
White	39.10%	339	867	10.00%	3.91%
Other	41.43%	273	659	7.60%	3.15%
Vietnamese	52.81%	301	570	6.58%	3.47%
Black	36.28%	41	113	1.30%	0.47%
Korean	39.13%	27	69	0.80%	0.31%
Filipino	35.38%	23	65	0.75%	0.27%
Chinese	29.09%	16	55	0.63%	0.18%
Asian or Pacific Islander	56.86%	29	51	0.59%	0.33%

Child and Adolescent Well-Care Visits (WCV)

The AWC HEDIS and MCAS measure was revised to Child and Adolescent Well-Care Visits (WCV) in October 2020. WCV measure reports three age stratifications and total rate: 3–11 years, 12–17 years, 18–21 years and total. Well-care visits were a top priority in 2020. The focus was on increasing compliance for annual well-care visits for adolescents. Since the measure was revised, there is no benchmark for MY 2020 to be trended. For the purposes of evaluation, data was pulled using AWC measure specifications unless noted otherwise.

Performance Against Goal:

There was no goal defined for MY2020. There are no benchmarks for comparison as WCV is treated as a first-year measure. AWC measure met MPL for MY2019. Table 1 identifies the WCV final HEDIS rate for MY2020. Table 2 is an overview of how adolescent well-care visits performed from 2018–20. WCV HEDIS measure was pulled for MY2020.

AWC Table 1: Child and Adolescent Well-Care Visits (WCV) Final HEDIS 2020 Rate

Child and Adolescent Well-Care Visits (WCV)	Rate
Child and Adolescent Well-Care Visits (3–11 years)	56.58%
Child and Adolescent Well-Care Visits (12–17 years)	54.04%
Child and Adolescent Well-Care Visits (18–21 years)	28.91%
Child and Adolescent Well-Care Visits (Total)	50.58%

AWC Figure 1: Final HEDIS Administrative Rates for Well-Care Visits, 2018–20

AWC Figure 1, identifies the administrative rate for annual well-care visits for 2018–20. Note, MY2018 and 2019 are based on AWC measure specifications (12–21 years old) and MY2020 is based on WCV specifications (3–21 years old). This data cannot be trended.

AWC Figure 2: Number of Members Compliant for AWC for MY 2020

AWC Figure 2 represents all new compliant members by month between January 2020 and December 2020 ($n_{outreached}$=62,943) for MY2020. Based on AWC MY2020 HEDIS specifications, these members fell in the AWC denominator (N=146,384). The AWC rate is 45.46% for members ages 12–21 years old. Note, Kaiser members are excluded from this data set since they are not outreached for initiatives. Numerator reflected here is lower than final administrative rate numerator (n_{actual}=66,553).

AWC Table 2: Adolescent Well-Care Visit Initiatives in 2020

Start Date	End Date	Initiative	Outreach Population	Description
1/1/2020	12/31/2020	Pay 4 Value program	N/A	Pay 4 Value program
1/01/2020	12/31/2020	Well-Care Visits 12–17 Member Incentive Program	10,525 approved; 594 denied	Health rewards program for Medi-Cal members 12–17 years old, who need to complete their annual well-care visit. ($25 gift card or movie tickets)
3/1/2020	12/31/2020	Well-Care Visits 12–17 Member Incentive Program Promotion	All, Public	Annual Well-Care Visits 12–17 program promoted on CalOptima's Health Rewards Program landing page
3/19/2020	N/A	Spring 2020 Medi-Cal Newsletter	HOH: 441,196	Medi-Cal Newsletter promoted adolescent wellness, including articles on: (1) Stay Well, Play Well ad, (2) Well-Child Visits, getting well-child visits are a key part of your child's health, (3) Infant and Child Car Seat Safety
5/22/2020	N/A	Health Guide 18–21 Newsletter Mailing	35,799 Medi-Cal Members	Health Guide Mailing to 18–21 years old population. Articles included: well-care visits, texting and drunk driving, sexually transmitted diseases preventions, managing stress
5/28/2020	N/A	Health Guide 13–17 Newsletter + AWC Incentive Mailing	74,651 Medi-Cal Members	Health Guide Mailing to 13–17 years old population. Articles included: well-care visits, immunizations, sexual health, bullying, behavioral health, healthy weight
7/15/2020	N/A	July 2020 Community Connections Newsletter	More than 2,700 readers	Community Connections Newsletter promoting the availability of Health Guide 13–17 and 18–21 Newsletter as resource to the community.
8/25/2020	N/A	Social Media Posting	All, Public	Stay Current on well-care visits, screenings, and immunizations (Instagram, Facebook, Twitter)

2020 Adolescent Well-Care Visit (AWC) Initiatives: Medi-Cal

1. Intervention: Annual Well-Care Visits Ages 12–17 Member Health Reward Program (1/1/20–12/31/20)

A. Description

Medi-Cal CalOptima members ages 12–17 years old are eligible for the Annual Well-Care Visit for Ages 12–17-member health reward if they complete a well-care visit this calendar year. The form must be completed and mailed or faxed to CalOptima within 8 weeks of completing the visit. Members approved received either three movie theater tickets or a $25 gift card.

B. Findings

AWC Table 3: Total AWC Member Health Reward Participation and HEDIS

AWC Health Reward Program	Forms Received	HEDIS Qualified	HEDIS Denominator	Health Reward Participation Rate
Annual Well-Care 12–17	11,119	10,290	146,384	7.03%

AWC Table 4: Members Participation in Well-Care Visit Ages 12–17 Member Health Reward by Written Language

Member Written Language	Count of Member Submissions for Well-Care Visit 12–17 Incentive	% of Total Submissions
Arabic	31	0.30%
Chinese	10	0.10%
English	3,014	29.29%
Farsi	38	0.37%
Korean	224	2.18%
Spanish	6,192	60.17%
Vietnamese	781	7.59%
Grand Total	10,290	

C. Analysis

1. 11,119 submissions were received, and 10,525 members were approved for the reward.
2. Of these approvals 9,808 fell into the AWC denominator and 9,424 were compliant for AWC.
3. Total member reward expenditure was approximately $263,125.
4. As identified in Table 2, the impact on HEDIS for this reward participation rate is low, 7.03%. Health Reward participation rate is calculated by 'HEDIS Qualified' divided by 'HEDIS Denominator'.
5. As identified in Table 3, the reward participation by member's written language. Majority of members preferred written language is Spanish (60.17%) and English (29.29%).

D. Barriers

1. Since the submissions are not verified through claims and encounters data, the reward form was taken at face value.
2. AWC denominator is large. Despite focusing on the 12–17 age group, the volume made it difficult to process all the forms received by mail and fax.
3. The verbiage for this reward is similar to the Well-Child Visit 1–3 and 4–6 reward which caused confusion. Providers thought this was included in the provider incentive program.
4. COVID-19 pandemic impacted preventative well-visits. Provider offices were not scheduling well-child visits at the peak of the pandemic, with office closures in Spring 2020. When offices reopened, scheduling was split to safeguard patients and staff. Well-care visits for adolescent age group were not prioritized.
5. Additionally, since students transitioned to at-home schooling/online learning due to the pandemic, vaccination mandates weren't enforced which typically aligns with well-care visits.

E. Opportunities for Improvement

1. The strategy to engage the adolescent population needs to be scalable to accommodate the large population. This incentive specifically targeted the 12–17 age group and had a higher response rate compared to the well-child visits reward for members 0–15 months. However, processing the rewards internally was not practical or sustainable.
2. Impacting such a large denominator with health rewards is likely not effective if managed internally. Other means of engaging this member population should focus on social media and creative engagement over health rewards. Since movie tickets and gift cards seem to be desirable for this age demographic, doing a raffle or event day giveaway to drive annual well-care visits may be impactful. This will help offset the reward form processing burden and minimize the impact on budgeted funds for quality initiatives.

2. Intervention

CalOptima Days at CHOC Health Alliance Sites (3/4/2020–3/5/2020)

A. Description: There was a concerted effort to increase the number of W15 visits starting in April 2019. CalOptima's collaboration with CHOC Health Alliance to host wellness events at CHOC Orange Clinic and Clinica CHOC Para Ninos site was held in March 2020. The clinics focused on outreaching and scheduling members who were due for W15, W34, or AWC. The incentive was based on a payment tier with a base pay for holding event of $500 and maximum incentive of $2,500; yielding $3,000 total. *Note: this is the same initiative as discussed earlier in the W30 section.*

B. Findings

1. CHOC Orange Clinic had two event days, 114 appointments scheduled, 103 attended and 80 confirmed CalOptima Medi-Cal members.
2. Clinica CHOC Para Ninos had two event days, 82 appointments scheduled, 64 attended and 45 confirmed CalOptima Medi-Cal members.

AWC Table 5: CHOC Health Alliance CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed Eligible Members	Incentive Amount
CHOC Orange Clinic	114	103	90.35%	80	$3,000
Clinica CHOC Para Ninos	82	64	78.05%	45	$3,000

C. Analysis

1. Total of $9,000 was incentivized to CHOC Health Alliance for hosting the CalOptima Day events and 125 eligible CalOptima Medi-Cal members were seen.
2. CHOC Health Alliance had a high attendance rate 78.05%–90.35%.
3. 36 members fell in the AWC denominator and all yielded a numerator hit.

D. Barriers

1. Initial delays due to communication and understanding discrepancies between CalOptima and participating entities were exacerbated by staffing changes.
2. Obtaining confirmed attendance list from sites for evaluation posed some difficulty. While clinic partners took on the task of performing outreach and mailing reminder letters, the coordination of delegating this task to one coordinator for each site was difficult.

E. Opportunities for Improvement

1. Due to the heavy resource demands, the time it takes for organization, coordination and execution, and the small impact on actual measure rates, CalOptima Days should not be continued without modifications.
2. Consider working with community partners to host health fairs where the outreach efforts are general and the documentation exchange will be limited to final completed attendance list verses outreach call list, mailers, schedule list to verify eligibility, and confirmed attendance list.
3. Future collaborative efforts should be preceded with confirmation of confirmed participation of champions at hosting site to avoid delays or confusion.

3. Intervention:
Health Guide 13–17 Newsletter and Annual Well-Care Visits Ages 12–17 Member Health Reward Mailing (5/28/20)

A. Description

The Health Guide 13–17 Years Newsletter and Annual Well-Care Visit for Ages 12–17 reward flyer was mailed to 74,651 Medi-Cal members in English, Spanish and Vietnamese in May 2020. Articles included: well-care visits, immunizations, sexual health, bullying, behavioral health, and information about healthy weight.

B. Findings

72,347 members who received the mailing fell in the AWC denominator.

C. Analysis

1. 61,527 had a well-care visit after receiving the mailing, but this compliance cannot be correlated with member targeted mailing.
2. While it is difficult to correlate the direct impact of mailings alone as an effective intervention towards compliance, multiple touches are believed to be effective in tandem with other member engagement strategies.

D. Barriers

No barriers experienced.

E. Opportunities for Improvement

1. Work directly with provider offices to identify which members scheduled for and attended their well-care visit because the reward is the motivating factor.
2. Anecdotally, some provider offices mentioned the reward as being an effective tool to get members to attend their well-care visit, especially as fear of going to the doctor's office grew during the COVID-19 pandemic. However, budget limitations dictated the conclusion of the AWC health reward program.

Additional Adolescent Well-Care Visit (AWC) Activities in 2020:

1. Well-Care Visits Ages 12–17 Member Health Reward Program was promoted on the CalOptima Member Health Rewards Program landing page from March to December 2020.
2. *Health Guide 18–21 Years Newsletter* (5/22/20). Targeted mailing outreached to 35,799 Medi-Cal members in English, Spanish and Vietnamese. Content included articles on well-care visits, texting and drunk driving, sexually transmitted diseases, managing stress, weight management and dating violence.
3. *Medi-Cal 2020 Spring Medi-Cal Newsletter Mailing* (3/19/2020). Newsletter included (1) Stay Well, Play Well advertisement, (2) Well-Child Visits, Getting Well-Child Visits Are a Key Part of Your Child's Health, and (3) Infant and Child Car Seat Safety article. Newsletter was mailed to 441,196 head of household Medi-Cal members.
4. July 2020 Community Connections Newsletter included the promotion of all Health Guide Newsletters (0–2 years, 3–6 years, 7–12 years, 13–17 years and 18–21 years old). Communication went out to all newsletter subscribers on 7/15/2020. Community Connections has more than 2,700 readers, representing local community-based organizations, non-profits, charities, local agencies, providers and entities.
5. Information to stay current on well-care visits, screenings and immunizations were posted to social media including Facebook (engagement rate 15/195 = 7.9%), Instagram (engagement rate 6/190 = 3.1%) and Twitter (engagement data N/A) (8/25/20).

2021 Adolescent Well-Care Visit (AWC) Initiatives: Medi-Cal

1. Back-To-School Vaccination Events held in collaboration with community partners: Anaheim Union High School (7/26/21), Northgate Market in Anaheim (7/31/21), Westminster Family Resource Center (8/18–8/19/20), and Boys & Girls Clubs of Garden Grove (9/11/21) provided resources to families which included but is not limited to: well-care screenings, vaccinations, dental screenings, fresh produce and supplies for back-to-school.
2. Health Guide 3–6 Newsletter and How to Protect Your Family from Lead Poisoning fact sheet mailing (4/29/21). Targeted mailing was sent to 47,901 Medi-Cal members ages 3–6 years old.
3. Back-To-School Vaccination Promotion advertisements were posted to social media periodically from June – August 2021. Animated advertisements included: 1) Don't Miss Your Shot, 2) Don't Wait Vaccinate, and 3) Let's Get Back Together Safely. These back-to-school advertisements were developed in English, Spanish and Vietnamese.
4. Young Adult Well-Care Visits for 18–21 year-olds animated videos were promoted on social media platforms (English: 6/30/20; Spanish and Vietnamese: 7/15/21).
5. Medi-Cal 2021 Summer Newsletter included the article: *During the COVID-19 Pandemic Is It Safe for Well-Care Visits*.

6. National Immunization Awareness Month (NIAM) observance on social media (August 2021) aligned with Centers for Disease Control and Prevention immunization efforts.
7. *Routine Immunizations and Well-Child Visits for Pediatrics*, Health Care Chat video went live on social media platforms on 8/27/21 discussing the importance of routine vaccinations. This was a new method of health education promotion via social media. These videos were in English, Spanish and Vietnamese and featured subject matter experts such as health educators and a pharmacist to elevate the message to as any members as possible.
8. Medi-Cal 2021 Summer Newsletter Mailing (7/06/2021). Newsletter included articles: *(1) During the COVID-19 Pandemic Is It Safe for Well-Care Visits*, (2) *Do You Know the Benefits of Family Meals?, (3) Be A.W.A.R.E. in the Sun* and the Let's Get Back Together Safely in Person advertisement. The member newsletter was mailed to 514,256 head of household Medi-Cal members.
9. Well-Child Visits, 3–17 years, text message campaign, planned for Q4 2021.

Opportunities for Improvement:

1. Since the AWC measure was revised to WCV, which captures the entire pediatric and adolescent population, ages 3–21 years old, a formal evaluation of this population should be conducted to identify data gaps and opportunities to work with high volume health networks or identified provider offices to improve their rate. This is necessary as the revised measure is captured administratively only.
2. Since the COVID-19 pandemic impacted health care in 2020, we need to closely monitor the WCV rate for a significant decrease and refocus interventions, if necessary.
3. Continue to foster working relationships with community-based organizations to collaborate hosting health fair events to reach members hesitant or unable to obtain care in the traditional provider office.
4. In examining the ethnicity breakdown of the WCV population (Table 6), ages 3–21 years old, White members make up 11.46% of the population, however their WCV rate is 38.11% which is much lower than Hispanic (52.85%) and Vietnamese (60.08%) members. This shows the need to include member demographic information in future data pulls to better plan initiatives to make a higher impact to subpopulations who are not getting care as much as other subpopulations. This approach will minimize the outreach population, which will decrease budgetary constraints and allow resources to focus on the subpopulation.
5. Assure future promotional campaigns leverage multiple outreach modalities to properly target members in subpopulations as culturally appropriate, e.g., if a subpopulation and ZIP code tend to use the bus, then complete a bus stop advertisement or if a certain subpopulation tends to get their information from the radio, then radio advertisements would be more appropriate.

AWC Table 6: HEDIS 2020 WCV Rate by Member Ethnicity, 10 Highest Volume Groups

Ethnicity Code (group)	WCV Numerator Rate	Numerator Count	Denominator Count	Percentage of Total Population	Impact on HEDIS Rate
Hispanic	52.85%	92,488	175,008	64.52%	34.10%
White	38.11%	11,843	31,078	11.46%	4.37%

Vietnamese	60.08%	13,524	22,511	8.30%	4.99%
No response, client declined to state	47.97%	7,513	15,663	5.77%	2.77%
Other	41.29%	3,224	7,808	2.88%	1.19%
Korean	55.79%	2,579	4,623	1.70%	0.95%
Black	35.68%	1,573	4,409	1.63%	0.58%
Filipino	45.09%	1,180	2,617	0.96%	0.44%
Chinese	42.91%	999	2,328	0.86%	0.37%
Asian or Pacific Islander	42.74%	765	1,790	0.66%	0.28%

Lead Screening in Children (LSC)

A. Program Description

LSC is a measure that is not held to a minimum performance level. However, the revised guidance outlined in the DHCS APL 20-016, and the effects of the COVID-19 pandemic present an opportunity for CalOptima to prioritize preventive care measures such as LSC.

CalOptima has engaged in efforts to ensure compliance with the DHCS All Plan Letter 20-016 and address blood lead screenings through various efforts paired with health network and provider education that emphasize the importance of timely blood lead screenings. To direct improvement efforts, CalOptima has set an objective to increase blood lead screening rates from 67.73% to 73.11% by December 31, 2023.

2021 Blood Lead Screening Initiatives:

Member Initiatives

1. Spring 2021 Medi-Cal Newsletter: Be Aware of Lead Poisoning article
2. Be Aware of Lead Poster – Distributed to Provider offices for display
3. Health Guide 3–6 Newsletter and How to Protect Your Family from Lead Poisoning fact sheet mailing (4/29/21). Targeted mailing outreached to 47,901 Medi-Cal members ages 3–6 years old.

Health Network/Provider Initiatives

1. Quarterly Blood Lead Screening (BLS) reports with member detail for those that do not meet the lead screenings testing intervals outlined in APL 20-016.
2. September 2021 update on quarterly BLS report at Health Network Quality Forum.
3. BLS updates through monthly Health Network quality meetings, Health Network Weekly Communication announcements and Provider Fax Blast.
4. Blood Lead Supplemental Report with DHCS data to support health networks with the reconciliation of members that complete blood lead screenings.

B. Interventions

1. Facebook, Twitter and Instagram posts during National Lead Poisoning Prevention Week.
2. Targeted mobile texting campaign.

3. Targeted social media campaign in geographic areas of low compliance related to the HEDIS measure for Lead Screening in Children
4. Spring 2022 Medi-Cal Newsletter: Call to Action

C. Analysis

We are developing a tool to provide analysis of the impact from the quarterly Blood Lead Screening report, which is targeted to be completed in 2022.

D. Barriers

1. A recent recall on LeadCare II, LeadCare Plus and LeadCare Ultra Blood Lead Tests may potentially influence MY2021 blood lead screening rates. The August 2021 prospective rates indicate a 7% decrease when compared with the August 2020 rate. This recall has the potential to result in a shortage of blood lead testing supplies or add barriers to members if this requires health networks to send members to complete lab testing. Findings indicate that members are not having these screenings completed after being provided with a lab slip.
2. The COVID-19 pandemic may have contributed to gaps in care, requiring focused efforts to improve preventive care services such as blood lead screening rates.
3. Reduced laboratory testing may be due to limited point of care blood lead testing opportunities.

E. Opportunities for Improvement

1. Blood Lead Screening in Children is not held to the MPL, but as deficiencies in blood lead screenings become increasingly prominent, there are additional opportunities that can be implemented to close HEDIS rates.
2. Offering blood lead screenings at community events in geographic locations with low utilization.
3. Expand the collection of lab data and results. Work with health networks to send point of care lab data through CalOptima's electronic data submission process.
4. Health networks can leverage Prop 56 provider-based payments to provide point of care blood lead screenings in provider offices and reduce the need for patient follow-up for these laboratory tests completed outside of the office visit.
5. Implement IVR robocall campaigns.

Section 3: Quality of Service

Member Experience

CalOptima annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal is to improve the overall member experience by better meeting our members' needs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CalOptima monitors member experience using the CAHPS survey and results, particularly the achievement score at various levels including plan and health network. The achievement score is the calculation of positive responses, typically identified as “Usually” or “Always” or rated top scores of “9 or 10.”

In winter 2020, the United States was struck by the COVID-19 pandemic. At that time, most of the United States had been under a lockdown (shelter-in-place) order. During this lockdown, routine and elective appointments and procedures had often been cancelled or pushed out to an unknown future date when restrictions are lifted. During surges in the virus, some hospital emergency rooms and ICUs reached capacity and had to turn people away. Field hospitals were set up in some areas to deal with the overcrowding and lack of PPE made it difficult to members to be seen. When possible, many medical appointments were converted to telehealth visits by phone or video. There have also been nationwide shortages of tests and vaccines for the virus, resulting in frustrations and delays for people seeking them.

While it is impossible to predict the effects of the pandemic on the survey results, composites such as Getting Needed Care and Getting Care Quickly; ratings of overall care, personal doctor, and health plan; as well as the response rate may all be affected. Due to this unique set of circumstances, the survey results in this report, and any comparisons to trend data, should be viewed with caution.

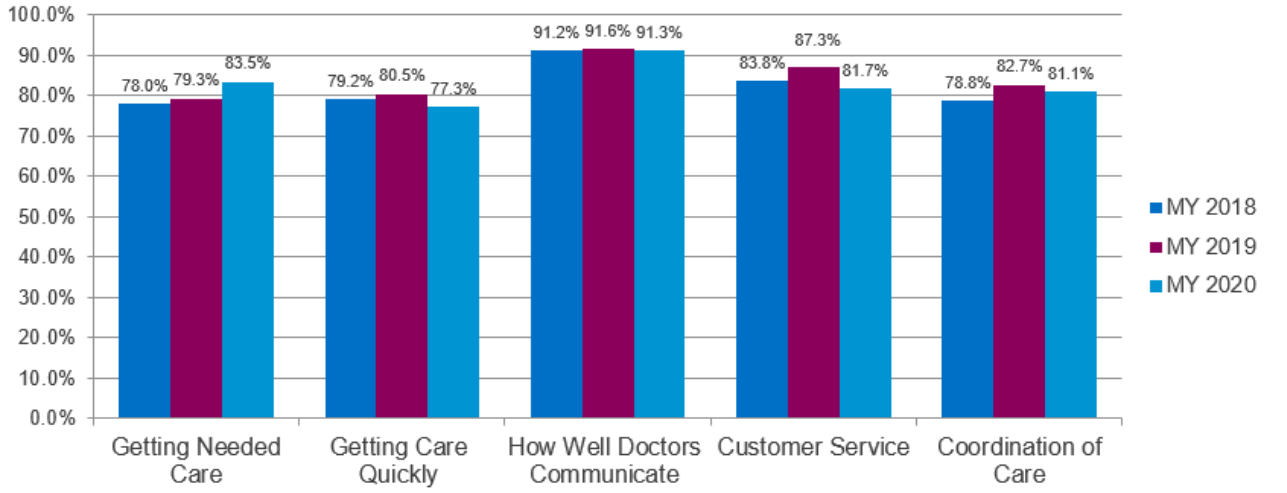
While the COVID-19 pandemic may have contributed, CalOptima’s response rate steadily decreased in the past few years. A lower response rate has led to CalOptima’s inability to report a valid CAHPS rate to NCQA for some measures due to a small denominator (N<100). As a result, CalOptima will be oversampling the population in the next survey cycle.

To better align with NCQA’s Health Plan Ratings methodology, CalOptima has begun benchmarking the plan’s CAHPS performance against the 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles for Medi-Cal. For OneCare, the Medicare Star Rating cut points will be used to benchmark CAHPS performance.

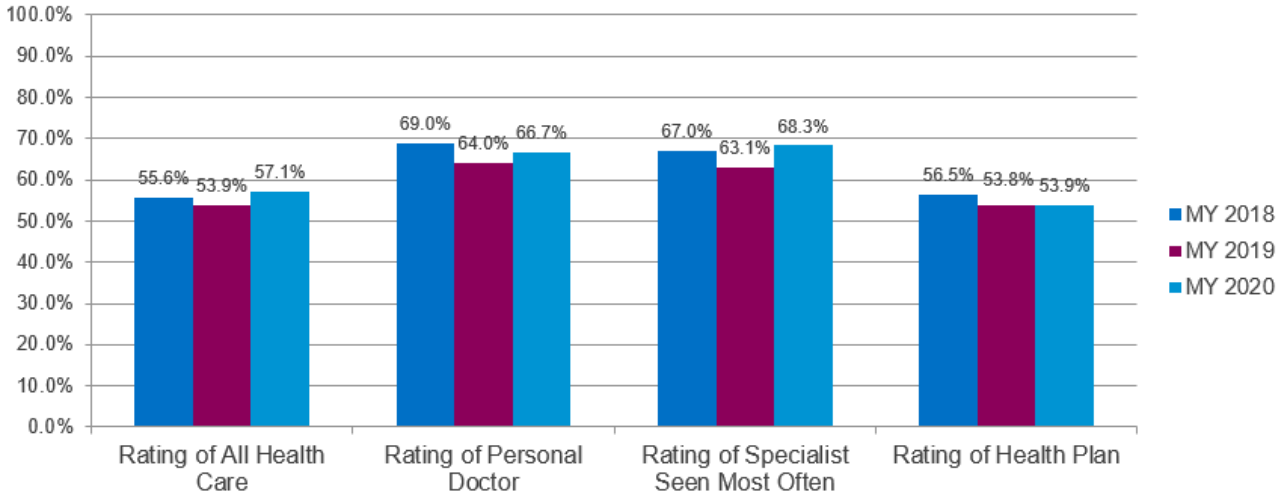
CAHPS Trend Analysis

Medi-Cal Adult CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



National Quality Compass	CalOptima MY 2020	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Getting Needed Care	83.5%	77.01%	81.58%	85.48%	88.35%
Getting Care Quickly	77.3%	75.36%	81.00%	84.91%	87.07%
How Well Doctors Communicate	91.3%	90.65%	92.42%	94.20%	95.74%
Customer Service	81.7%	86.06%	88.57%	90.69%	92.37%
Coordination of Care	81.1%	79.21%	83.49%	87.59%	90.23%

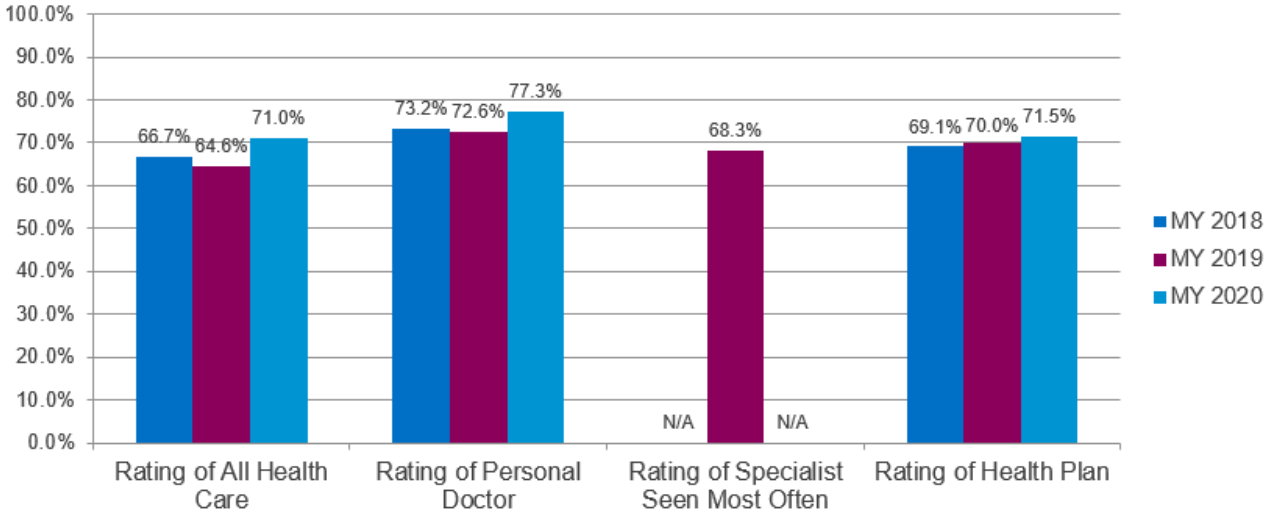


National Quality Compass	CalOptima MY 2020	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Rating of All Health Care	57.1%	51.32%	55.34%	59.55%	64.49%
Rating of Personal Doctor	66.7%	62.75%	67.68%	71.74%	75.68%
Rating of Specialist Seen Most Often	68.3%	62.75%	67.42%	72.48%	75.55%
Rating of Health Plan	53.9%	54.04%	59.40%	65.63%	70.18%

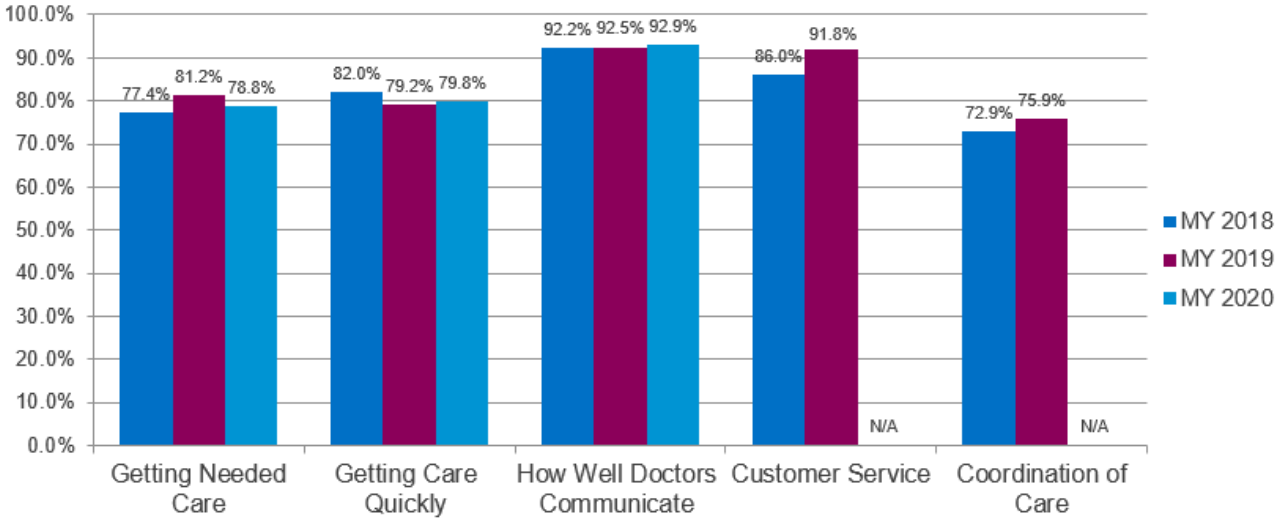
Red denotes performance below the 10th percentile

Medi-Cal Child CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



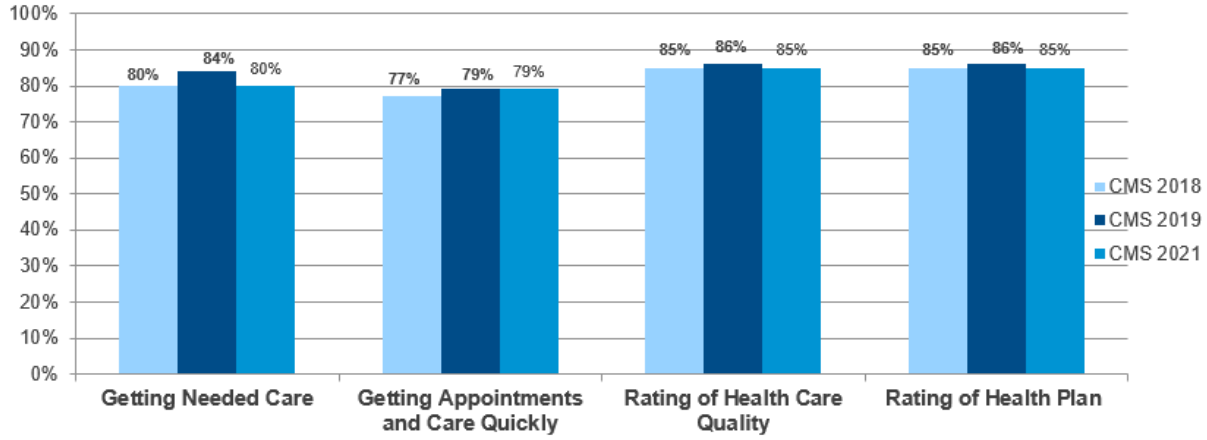
National Quality Compass	CalOptima MY 2020	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Rating of All Health Care	71.0%	66.07%	70.27%	73.99%	77.65%
Rating of Personal Doctor	77.3%	73.14%	77.19%	80.67%	83.33%
Rating of Specialist Seen Most Often	NA	67.98%	73.58%	74.38%	76.8%
Rating of Health Plan	71.5%	63.64%	70.57%	74.55%	77.93%



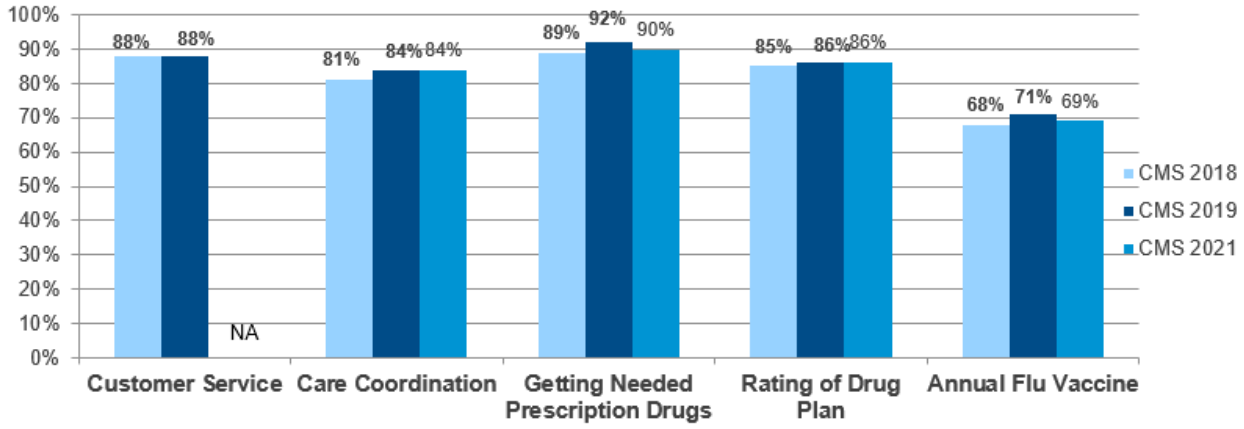
National Quality Compass	CalOptima MY 2020	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Getting Needed Care	78.81%	80.72%	84.47%	88.33%	91.14%
Getting Care Quickly	79.79%	84.96%	89.59%	92.89%	95.03%
How Well Doctors Communicate	92.89%	92.50%	94.66%	96.40%	97.60%
Customer Service	NA	85.14%	87.25%	90.34%	92.90%
Coordination of Care	NA	79.66%	85.34%	88.24%	90.65%

OneCare CAHPS Survey Results

Goal: To meet the CMS 3 Star Rating



Measure	Mean Score	Statistical Significance	Star Rating for 2021 CAHPS Score	Star Rating for 2020 CAHPS Score	Star Rating for 2019 CAHPS Score
Getting Needed Care	80	No difference	2	4	2
Getting Appointments and Care Quickly	79	No difference	3	4	3
Rating of Health Care Quality	85	No difference	2	3	3
Rating of Health Plan	85	Below Average	2	3	3



Measure	Mean Score	Statistical Significance	2021 Star Rating	Star Rating for 2020 CAHPS Score	Star Rating for 2019 CAHPS Score
Customer Service	N/A	N/A	N/A	2	2
Care Coordination	84	No difference	2	2	1
Getting Needed Prescription Drugs	90	No difference	3	4	3
Rating of Drug Plan	86	No difference	3	4	4
Annual Flu Vaccine	69	Below Average	2	3	2

OCC CAHPS Survey Results

Goal: To meet the CMS National MMP Average

CAHPS Measures	OCC CMS 2018 Results	OCC CMS 2019 Results	OCC CMS 2021 Results	CMS National MMP Results	Statistical Significance **
Getting Needed Care	3.33	3.27	3.37 (+)	3.43	Below Avg.
Getting Appointments and Care Quickly	3.29	3.20	3.14 (-)	3.30	Below Avg.
Rating of Health Care Quality	8.40	8.20	8.6 (+)	8.7	Below Avg.
Rating of Health Plan	8.50	8.50	8.50 (~)	8.8	Below Avg
Customer Service	N/A	3.58	3.62 (+)	3.68	Below Avg.
Care Coordination	3.52	3.47	3.52 (+)	3.57	Below Avg.
Getting Needed Prescription Drugs	NA	3.57	3.65 (+)	3.71	Below Avg.
Rating of Drug plan	8.40	8.30	8.50 (+)	8.8	Below Avg.

Case mix adjusted mean on a 1-4 scale. +/-=score increase/decrease from 2019.
~=no change in score from 2019.

CalOptima reviewed all the MY2020 CAHPS rates in detail and compared them with the benchmarks and found that CAHPS measures remain below the 66th percentile for Medi-Cal, below a CMS 4-Star Rating for OneCare and considered “Below Average” for OneCare Connect. With the exception of 3 OneCare CAHPS measures meeting a CMS 3-Star Rating, CalOptima did not meet the goals set for CAHPS.

CalOptima continues to identify that access-related measures consistently perform below goal. The “Getting Needed Care and Getting Care Quickly” measures did not meet goal and scores from the Medi-Cal Child Survey even sit below the 10th percentile. For OneCare Connect the “Getting Appointments and Care Quickly” rate has shown a decrease from the previous year. The score for the “Coordination of Care” measure for the Medi-Cal Adult Survey only met the 10th percentile and a 2-Star Rating for the OneCare Survey. As a result, CalOptima will continue to focus on these measures in 2022.

Behavioral Health Member Experience Surveys

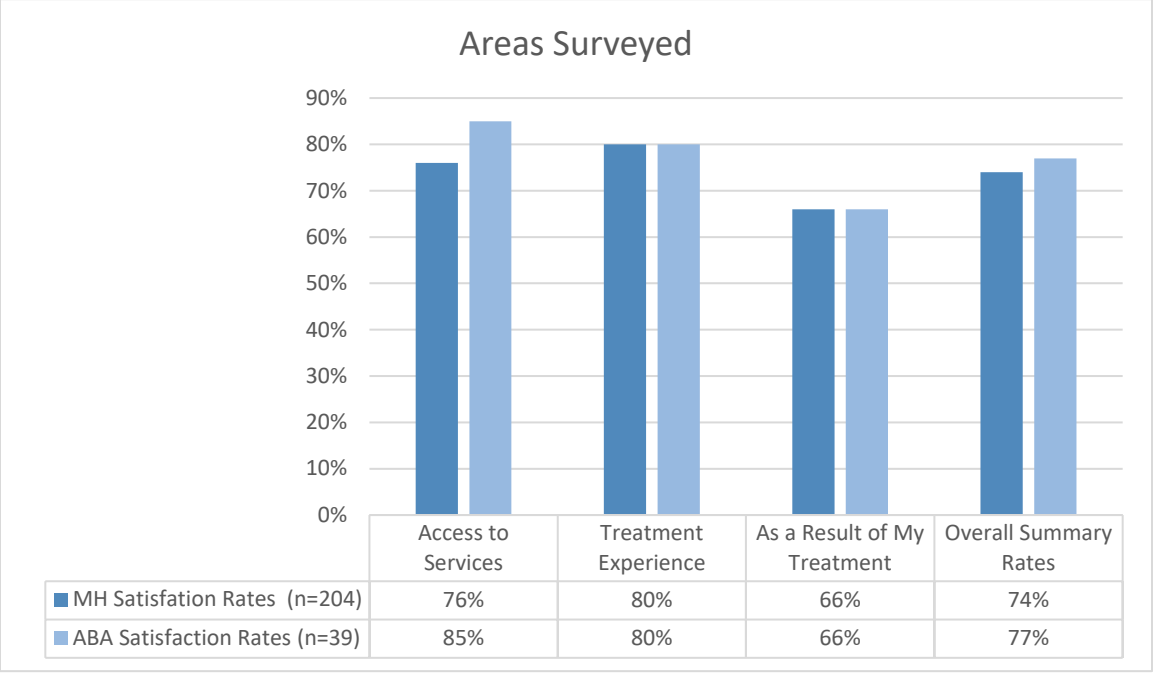
CalOptima conducts a comprehensive Behavioral Health survey and analysis annually to assess member satisfaction specific to Behavioral Health services and care received. CalOptima worked with an outside vendor to field the 2021 Behavioral Health Member Experience Surveys to measure member satisfaction on BH services received in 2020. Two separate surveys were administered: the Behavioral Health Member Satisfaction: Applied Behavior Analysis (ABA) Services Survey and the

Behavioral Health Member Satisfaction: Mental Health (MH) Services Survey. The MH version of the survey assesses for both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The consistent areas surveyed annually are Access to Services, Treatment Experience and As a Result of my Treatment. Additional questions on telehealth services, duration of treatment and overall experience were included based on feedback received from the Behavioral Health Quality Improvement (BHQI) Workgroup, Member Experience Committee and Quality Improvement Committee (QIC).

A two-wave mailout survey methodology using a random sample size of 1,800 members was used to carry out the survey. Members of all ages and genders were surveyed. The survey was available to all members in their preferred language. Questions were scored on a five-point Likert scale that allowed the members to express how much they agree or disagree with a particular statement and included an option of Not Applicable (NA). The response rate for the MH services survey was 14% for a total of 204 completed surveys and 17% for a total of 39 completed surveys for ABA services.

CalOptima has established an overall satisfaction goal of 85%. Satisfaction rates for telehealth experience shown medication services fell below the intended goal (MH survey 80%; ABA 71%). In addition, satisfaction rates were significantly lower when asked if given the option to continue to receive services with their provider using telehealth (MH survey 48%; ABA 24%). Results for lower satisfaction rates for ABA services may be due to services typically conducted in the home. For MH services, lower rates may be a result of lack of privacy, not having an area where members feel comfortable disclosing personal information.

Goal: To meet Internal Benchmark of 85%



	Access to Services	Treatment Experience	As a Result of My Treatment	Overall Summary Rates
MH Satisfation Rates (n=204)	76%	80%	66%	74%
ABA Satisfaction Rates (n=39)	85%	80%	66%	77%

2021 Overall Summary Rates		Goal	Gap to Goal
Mental Health Survey	74%	85%	-11%
ABA Survey	77%	85%	-8%

The Overall Member Experience Survey rates for areas surveyed consistently year-to-year (i.e., Access to Services, Treatment Experience and As a Result of My Treatment) did not meet the intended goal of 85%. The gap to goal remained the same for the MH survey results for 2020 and 2021 at 11%. However, the gap to goal for ABA survey results decreased from 11% in 2020 to 8% in 2021. As a Result of My Treatment received the lowest satisfaction rate of the areas surveyed, as seen in prior years. To address potential misunderstanding of questions in this area, a new question was added this year directly asking members how they feel in comparison to starting treatment with their provider. The direct question produced significantly higher results (MH 80% and ABA 68% responded feeling Much/Slightly Better). Another question added this year was duration of treatment to assess for correlations with satisfaction rates. 42% of members responding to the MH survey reported feeling Much/Slightly Better compared with how they were feeling before seeing their provider were in treatment for over 12 months. 46% reported feeling Much/Slightly Better compared to how I was feeling before seeing their ABA provider were in treatment for more than 12 months as well. Review of results elicited feedback to increase sample size to improve response rates to better represent members receiving services and to share responses with Provider Relations to receive provider perspectives on how to improve member satisfaction scores and the overall member experience of care.

Grievances and Appeals

CalOptima monitors member experience using the grievance and appeals data trended by quarter for 2021, where data for this evaluation only includes data from Q1 and Q2. For Medi-Cal, the top two categories with the most grievances are Quality of Service (62%) and Access (19%) making up a total 81% of all grievances the first half of 2021. While there was a small decrease in the percentage of Quality of Service grievances from the previous year, there was a 7 percentage point increase in access-related grievances, which may be likely be attributed to the COVID-19 national health emergency. For CMS grievances, Medical Necessity makes up 53% and 72% of all grievances for OneCare and OneCare Connect, respectively. When looking more closely at the data, the top grievances sub-categories are appointment availability, telephone accessibility, transportation/non-medical and delay in service, which includes delay in referral/authorization. As a result, CalOptima will focus on these measures in 2022.

Access to Care

CalOptima monitors availability and accessibility on an annual basis. The evidence is clear that timely access to health care services results in better health outcomes, reduced health disparities and lower spending and better overall member satisfaction with health care.

Timely Access Survey

For this year, CalOptima fielded a survey with a mystery shopper and direct survey methodology to collect appointment and telephone wait times and compare them to standards from DHCS and CMS. A compliance rate is calculated by standard for each provider type.

In early 2020, the world was struck by the COVID-19 pandemic. In light of the COVID-19 pandemic, CalOptima placed a temporary hold on conducting the Timely Access Survey. A hold was necessary as call centers were closed due to statewide shelter-in-place mandates. In addition, CalOptima also wanted to ease the burden and allow network providers to focus operations on COVID-19. This decision to place a hold on the survey was aligned with DHCS' discussion to hold their timely access survey of the plans. However, in November 2020, CalOptima restarted fielding the Timely Access Survey and the survey was fielded from November 2020 to June 2021.

For the 2020 Timely Access Survey, the methodology was revised to incorporate a direct call methodology on top of the mystery shopper call methodology to increase overall response rate, particularly for the urgent appointments and behavioral health providers. A sampling methodology was also implemented for this survey cycle.

As part of this survey, a sample size of 3,629 primary care providers, high-volume and high-impact specialists, BH providers and ancillary providers were pulled for outreach and data collection.

Goal:

1. To meet internal goal of 80% for each individual measure and practitioner types.
2. To increase the PCP and Specialist for routine and specialist compliance rates by 10 percentage points.

Timely Access Survey Analysis

Of the survey population across all programs, where the vendor was able to obtain an appointment for comparison against the standards, the data shows that the rates have improvement from the previous survey cycle. The following appointment availability standards newly met the internal goal of 80% in the 2020 Timely Access Survey: OB/GYN Prenatal, Routine Psychiatry and Routine Ancillary. The appointment types for routine and urgent care visits for primary care, specialty care and non-physician behavioral health provider (NPBH) continue to be an opportunity for improvement. While there was a significant increase in rates for both PCP and specialist for urgent appointments (over 40 percentage points) from the previous survey cycle meeting the goal, PCP and specialist routine only had a 9 percentage point increase and did not meet the goal. These measures did not meet the internal goal of 80%. Consistent with previous year, rates tend to be lower for urgent and specialty appointments and appointments. In regard to telephone access, CalOptima met the internal goal for telephone triage within 30 minutes and flexibility in rescheduling members with disabilities, but did not met the internal 80% goal for providers having a live person answer the phone in 30 seconds and instructions to callers in a recording if there is an emergency. Based on the review of timely access study results, appointment and telephone access continue to be an area of focus. When evaluating timely access for each of CalOptima's delegated health networks, the health networks similarly did not meet the internal goal of 80% for the same standards.

Network Adequacy — Time or Distance Analysis

CalOptima monitors network adequacy on a quarterly basis by running reports to evaluate whether the plan meets the time and distance standards established by CMS and DHCS. In 2021, DHCS issued an updated All-Plan Letter on Network Certification and provided more guidance on meeting the standards and on how to run the reports. Plans are now only required to meet time or distance standards where each ZIP code must have members meeting 100% access. Plans also need to account for anticipated membership using the 100 points of light methodology pulling from the 2010 census. For all programs, the plan has met the time or distance standards. When evaluating network adequacy for each of CalOptima's delegated health networks, the health networks did not meet all the time or distance standards. They had challenges providing geographic coverage for specialists, particularly in south Orange County. As required by DHCS, CalOptima is required to certify all delegated health networks by July 2022 for Medi-Cal. Health networks with ZIP code/provider type combinations not meeting time or distance standards must submit a provider of that specialty and in that ZIP code area, through the Alternate Access Template, to meet the gap. CalOptima intends to have each delegated network fill the time/distance gap and be certified by July 2022.

Comparison to Complaints/Appeals

When the CAHPS results were compared to access grievances, CalOptima found that access grievances make up about 20% of all grievances in the first half of 2021 for Medi-Cal. Compared with the previous year, the percentage of access-related grievances have increased from last year. For OneCare and OneCare Connect, Medical Necessity makes up 53% and 72% of all grievances for OneCare and OneCare Connect, respectively. The top three sub-categories of access grievances are appointment availability, telephone accessibility and specialty care. Of the access-related grievances, appointment availability and telephone accessibility continue to be a pain point for members with approximately 35% and 24% of all access-related grievances, respectively, for Medi-Cal.

Member Experience Activities Completed in 2021

The Member Experience Subcommittee identified access, member engagement and virtual care strategies as the areas of focus for 2021.

Virtual Care Initiatives

On May 7, 2020, CalOptima obtained Board approval for overall Virtual Care Strategy and Roadmap and the Virtual Strategies Workgroup continued to implement these strategies throughout 2021.

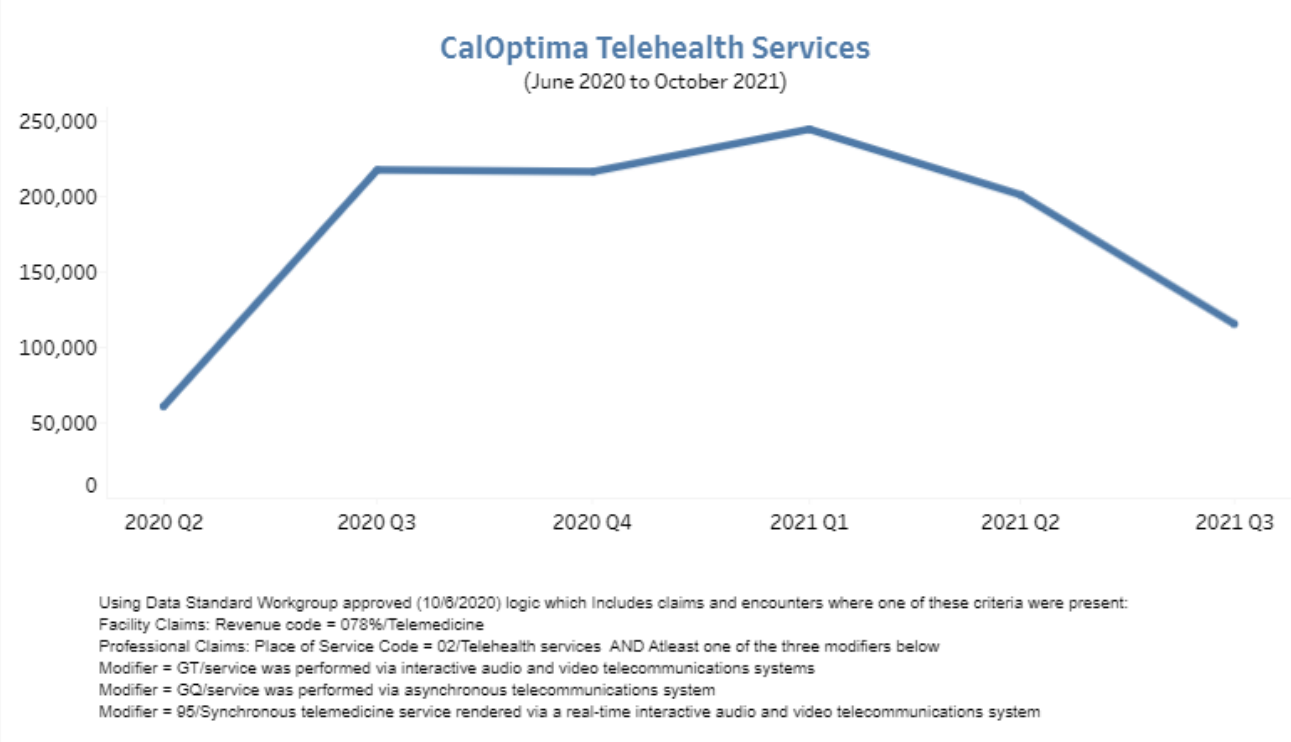
1. Member Texting: CalOptima secured Board approval for three years of funding and contracted with mPulse on 7/28/20 to provide one-way and two-way interactive texting campaigns to members. In March, CalOptima obtained DHCS approval and the initial campaign on COVID-19 Vaccination was launched on March 22, 2021, to more than 300,000 households and the tool has been useful in getting information out to members quickly. Since then, CalOptima has launched a member texting campaign on COVID-19 education and clinics, well child programs and other member education. While opt-out rates are increasing as additional campaigns are executed, the Telephone Consumer Protection Act (TCPA) project continues to obtain member consent and approximately 137,540 member consents were obtained as of 6/25/21.
2. PACE Telehealth Solution: CalOptima secured Board approval for funding to implement a technology platform using VSee to support PACE staff (clinicians) virtual visits with participants at home or other remote locations that work in conjunction with

Facetime/Google Duo during COVID-19 and support long-term need to engage participants at home. Pilot launched in October 2020 and rolled out to all PACE clinical teams by early December. As of July 2021, the telehealth engagement is 65% and there are more than 1,200 telehealth encounters.

3. eConsult: An eConsult system allows PCPs and specialists to securely share health information and discuss patient care that may replace the requirement for authorizations. A RFP had been issued in the end of 2020, vendor selection has taken place, and CalOptima intends to finalize contract negotiations and prepare for Board presentation to obtain approval and execute the contract.
4. Behavioral Health (BH) Virtual Visits: CalOptima contracted with Bright Heart to provide BH virtual visits to our members. Bright Heart providers have been credentialed and visits began in August 2020. BH providers have been utilizing referrals for BH services, and member liaisons have been utilizing referrals for medication management services. As of May 2021, there were 1,184 Bright Heart Telehealth Services to date.
5. Virtual Visit: CalOptima intends to provide 24/7 direct access to physician virtual visits via website link or nurse advice line referral. CalOptima obtained Board approval for funding and CalOptima plans to re-issue an RFP in Q3 2021.

The goal was to successfully launch all five virtual care initiatives in 2021. Three initiatives (Member Texting, PACE Telehealth Solutions and Behavioral Health Virtual Visits) were launched in late 2020 or 2021. eConsults and Virtual Visits are still in progress.

Telehealth Utilization Trend Analysis



CalOptima began implementation of the virtual care strategies in August 2020, beginning with the Bright Hearts Program. Along with efforts to promote telehealth services, there was an increase in telehealth utilization from Q2 2020 to Q1 2021, which would reflect the height of the COVID-19

national pandemic where provider offices were closed to in-person visits and converted to telehealth visits as an alternative. In Q1 2021, as provider offices began to open and again offer in-person visits, there was a steady decrease in telehealth utilization, with 244,22 visits in Q1 2021 and only 115,757 visits for Q3 2021. The goal was to increase utilization to 30% (visit count/#members) and CalOptima did not meet that in Q3 2021 with only 13.6%. There was also a decrease in the member telehealth usage rate from 8.8% to 5.2% and the goal of 10% was not met.

At this time, this metric may not be the best indicator of success of the virtual care strategy as many of the programs have yet to launch. In addition, a decrease in utilization may not be an indication of less access or satisfaction since members now have more options and modalities when seeking care.

Member Engagement

1. In 2021, the following efforts were made to promote the self-service options on the Member Portal:
    a. New recorded announcements on the CalOptima's customer service telephone tree educating members on member portal services.
    b. Notice was mailed to members on January 2021 about the TCPA and the member portal.
    c. Customer Service staff educating members about Health Rewards Incentives for COVID-19 vaccinations and the member portal.
2. In 2021, the following member outreach campaigns were implemented:
    a. Informing members of specific PCP terminating from the CalOptima and assisting members with locating a new PCP.
    b. Informing members who are deeming and educating members on how to resolve their Medi-Cal eligibility issue.
    c. Informing members who have a share of cost and educating members on contacting social services to assist with share of cost status and/or questions.
    d. Following up with new enrollees after 45 days of being enrolled with the plan to check in on how everything is working and offer assistance if necessary.
    e. Outreaching to members to wish them a Happy Birthday.

Expanding the Provider Network

CalOptima has focused on recruiting hard-to-access specialties in our CalOptima Community Network. As of end of Q3 2021, 59 executed agreements, 23 in active negotiation, and six in credentialing for the following specialties: Dermatology, Gastroenterology, Nephrology and Orthopedic Surgery. The goal is to recruit 25% of 135 hard-to-access leads (34 providers). CalOptima met that goal by executing 59 agreements.

Overall Assessment of Member Experience and Access to Care

Based on the review of CAHPS, Timely Access study, Time/Distance Analysis and complaints data, the general theme that stands out is that appointment access, delay in care and telephone access is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. It also shows that members are not always reaching providers when they call to make an appointment. This has a significant impact on how members respond on the member CAHPS survey for questions related to getting care quickly and getting needed care. In 2022, CalOptima will continue focusing on the key initiatives that were implemented in 2021 and develop

additional initiatives to improve timely access to care. The section below describes the barriers that continue to exist that maybe impacting timely access to care.

Existing Barriers
Based on the member experience data, CalOptima has identified the following areas as critical measures, making them the highest priority in terms of making improvements.

A group of subject matter experts from across the organization completed a detailed barrier analysis:

Access and Availability
1. Lack of extended office hours for appointments can be a significant barrier.
2. PCPs have too many members in their panel.
3. There may be an adequate number of practitioners in CalOptima's panel but not all providers have open panels or are available to see CalOptima new patients.
    a. CalOptima is a delegated model and members are only able to see a provider in their health network.
    b. A particular PCP and specialist group will not see members that are not in their system.
4. Certain geographic areas in Orange County, particularly south Orange County, do not have an adequate number of specialists for a particular type of specialty (i.e., pediatric subspecialties, oncologists, rheumatologists, etc.).
5. Not enough specialists are willing to contract with CalOptima.
    a. Low reimbursement rates in comparison with other types of health insurance.

Provider Data Quality
1. Members not always able to get through to their provider to make an appointment.
    a. Member calls reached the wrong number, a number where the provider is not recognized or no longer at that location, or no answer at all.
2. Members are referred to and approvals are sent to specialists who cannot see the patient.
    a. Specialists/subspecialties/area focus is not clear, or information is not captured.
3. Open/closed panel is not up to date.
    a. No real-time process to collect correct information about which specialists have open panels and available appointments to see patients.
4. System issue: FACETS shows no longer accepting patients, but Guiding Care shows as participating without any restrictions.

Prior Authorization Process
1. Timelines of submission of PCP and specialist in an issue. Provider office staff wait to submit the authorization request.
2. Providers do not always send all the information needed to make a decision at the time of the initial submission. Resubmission is sometimes required and may cause delay in obtaining services.
3. Since UCI provides a tertiary level of care, all referrals need to be reviewed and cannot go through an auto authorization process, which may make members feel like it takes a long time.

Opportunities for Member Experience in 2022
The Member Experience Subcommittee identified access to care as the areas of focus for 2021.

In order to accomplish this goal, CalOptima is developing several interventions that include, but are not limited, to the following:

1. Request action from health networks with low CAHPS scores and health networks not meeting timely access standards, in the form of a Plan-Do-Study-Act (PDSA), in order to improve their overall member experience. Health networks will be asked to review their CAHPS and Timely Access results and identify plans to improve areas with low performance. Upon CalOptima's approval of the plan, health networks shall implement and then evaluate the plan to determine its success and generalizability.
2. Continue to implement the virtual care initiatives in the Virtual Care Strategy and Roadmap, including implementation of a virtual visit system and an eConsult system to serve as a peer-to-peer communication messaging platform between PCPs and specialists, which will improve patient access to specialty care and overall quality of care.
3. Continue to monitor PCPs to determine if their panel size is too large to provide care for our members. Ensure quarterly provider overcapacity notification letters are sent in a timely manner. Close panels for providers that are not meeting the capacity.
4. Network adequacy monitoring by health network. As DHCS requires all plans to certify their delegated networks on network adequacy access performance by July 1, 2022, CalOptima has already begun monitoring adequacy of network at the health network level. Beginning 2021, health networks began receiving their quarterly time/distance accessibility reports and in July 2021 health networks were asked to provide CalOptima with a list of providers to meet their time/distance gaps by completing the Alternate Access Template. Reports in Q4 2021 will include mandatory provider types and provider to member ratios.
5. Provider outreach and education via a notification letter to providers not meeting the timely access standards. An escalation process has been developed to track continue instances of non-compliance that may lead to further action (i.e. corrective action plan, freezing panels, sanctions, etc.).
6. Provider data validation to ensure that members have the correct contact information in the provider directory. Provider outreach to providers deemed as unable to reach as part of the Timely Access Survey.

Section 4: Safety of Clinical care
Post-Acute Infection Prevention Quality Initiative (PIPQI)

A. Description

PIPQI is a CalOptima quality initiative program aimed to reduce antibiotic-resistant bacteria in nursing homes. Participating nursing facilities utilize Chlorhexidine Gluconate (CHG) soap for all baths and showers and Iodophor nasal swabs five days per week every other week. Currently, 26 nursing facilities participate in PIPQI.

B. Interventions

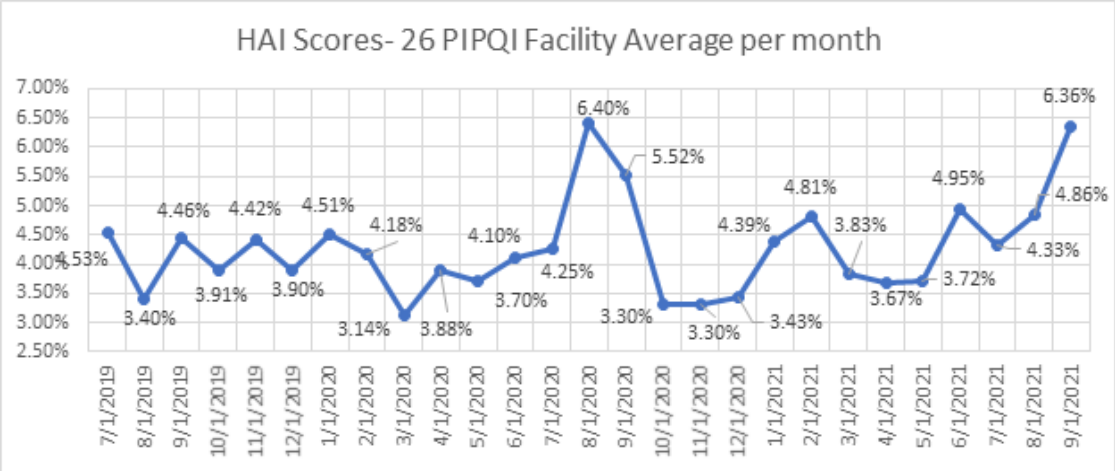
1. The PIPQI team began gearing the trainings toward helping the facilities use the product purchasing data to gauge how compliant their staff and residents are with following the PIPQI Protocols.
2. The PIPQI team has been on-site in the facilities since March 2021, offering hands-on training and education to the staff.

3. The PIPQI team has offered to support the individual facilities by hosting trainings for new staff and being available during skills days.
4. PIPQI Brand recognition is low in the community because many facilities still view this project as an extension of the UCI SHEILD program. The CalOptima PIPQI team is working toward improving the branding on the training materials given to the nursing facilities.

C. Findings

Prior to the implementation of PIPQI, the University of California, Irvine (UCI) conducted a program called SHEILD following the same infection prevention principles. The PIPQI team uses one training video, created by the UCI SHEILD Team, to review with all participating nursing facilities monthly since March of 2020. Quality performance measures were being monitored in 2021 including Healthcare Associated Infections (HAI) Score trends, quantitative analysis of products purchased compared to the number of licensed beds and the relationship between proper product utilization and hospital admission rates for MDRO's as a primary or secondary diagnosis. PIPQI hopes to expand to additional facilities in 2022.

HAI scores are submitted each month by the Nursing Facility staff members to the CalOptima PIPQI Nurses. Using this data, the CalOptima Nurses track and trend HAI events in each nursing facility and provide feedback to the facilities on their individual trends. The chart below shows the averages for all facilities throughout the course of the PIPQI Program. The highest peak was in August of 2020, and we are starting to again see an upward trend going into the fall of 2021. Lower scores indicate fewer infections in the nursing homes and the staff works with facilities to decrease or maintain their individual HAI scores.



In addition to collecting HAI Scores, the CalOptima PIPQI team collects invoices showing proof of product purchasing. In 2021, we began to look at the quantitative data in more detail to track trends from individual nursing facilities to assist them with ensuring they have adequate quantities available for their residents. A data set was created in January 2021 that determined a product quantity for each facility based on the 75% of the licensed beds being filled. Once that was completed, we compared the amount projected for the facilities to the

actual invoices given to the PIPQI staff. Below are representations of the Chlorhexidine Gluconate (CHG) and the Iodophor.

CHG Invoice Data Collection (260 possible invoices)

	No Purchase Proof	118
	Purchased less than 50%	66
	Purchased 51-79%	24
	Purchased 80-120%	31
	Purchased greater than 120%	21

Iodophor Invoice Data Collection (260 possible invoices)

	No Purchase Proof	171
	Purchased less than 50%	20
	Purchased 51-79%	18
	Purchased 80-120%	16
	Purchased greater than 120%	35

D. Barriers

The baseline data is showing there are still a few gaps in product purchasing and the data being made accessible to the CalOptima Employees.

1. The facilities did not submit 45% of the CHG Invoices and 66% of the Iodophor invoices despite the in-person, telephonic and e-mail reminders.
2. There has been a high staff turnover rate in the nursing facilities including central supply and housekeeping employees due to the effects of the pandemic.
3. The census' in the nursing facilities have been fluctuating and there are times when they are at less than 75% capacity, however this is a rare occurrence an only contributes to a small margin of data.
4. Of the invoices submitted, there are only a small margin that are purchasing at or above the projected quantities. Since these quantities are based on each resident following the protocols as directed, (4oz bath/ shower every other day and 10 Iodophor Swabs/ month), we are seeing some facilities show compliance with or above average utilization of the products.
5. COVID-19 presents the following barriers:
    a. Nursing facilities are short staffed and overworked leaving little time to participate in PIPQI monitoring protocol.

b. High turnover rates in facilities creates a need for constant PIPQI training.
c. Due to COVID-19, CalOptima nurses were not allowed to conduct on-site visits for monitoring or training of facility staff from March 2020 until March 2021.
d. The CHG Swab testing approved in the April 2020 COBAR was placed on hold for the duration of the Public Health Emergency, with the Incentive Funds being repurposed to help the facilities cover staffing costs and additional Personal Protective Equipment (PPE) purchasing.

E. Opportunities for Improvement

Some of the most prominent barriers to the PIPQI program are the lack of brand recognition in the community as well as the facilities under purchasing the two products. To mitigate those in the future and move the program forward, we have created a few areas in which we are focusing our attention.

The first will be working with the facilities to ensure they are purchasing proper quantities of the two products. Often, there is someone at the facility who either works in central supply or housekeeping that is responsible for the coordination of these product purchasing. These staff members may or may not have received training from their organization about how much to order of the products. We have implemented trainings for those staff members to help give them guidelines on how much product they should anticipate needing to purchase. We have created par levels based on projected census levels. By the Central Supply staff understanding how much product they need, they can help guide us on supply chain issues and how quickly their staff is going through the products as well as helping to track the needed invoice data.

Orange County COVID Nursing Home Prevention Program

A. Description

Beginning May 2020, CalOptima partnered with the Orange County Health Care Agency and the University of California, Irvine (UCI) to provide COVID-19 support to OC nursing homes to improve prevention readiness and restrict, to the extent possible, the impact of the anticipated COVID-19 surge to Orange County Nursing Homes. As of August 2021, the following interventions have been completed and finding identified:

B. Interventions:

1. UCI developed a toolkit and implemented training for the OC nursing home staff.
2. OC Nursing Home COVID-19 Prevention Team has provided consultative services provided to OC nursing homes:
    a. 12 nursing homes received an intensive training program with weekly feedback of staff safety metrics;
    b. 12 nursing homes receive training on surveillance on PCR testing of residents and staff, which included training to obtain nasopharyngeal samples. PCR testing of residents and staff was used to inform the trajectory for the spread and immunity of COVID-19.

    c. 150 hours of consultation to 31 additional OC nursing homes for COVID-19 prevention.
3. A confidential helpline for COVID-19 questions and inquiries was launched in June 2020, which addressed 157 inquiries regarding questions about COVID-19 prevention, vaccines, and safety.
4. An online toolkit was developed which contained 3 modules, 51 documents and 20 videos. To date, there have been over 3,000 views.
5. Informational Wall-Clings were printed, which included 10 different posters. The posters addressed the symptoms of COVID-19, breakroom safety, and hand hygiene/mask safety. More than 1,200 copies were distributed to the nursing homes.
6. Webinars were hosted 6 times with invitations to all Orange County nursing homes. Each webinar had approximately 60 attendees.
7. Encouraged COVID-19 vaccine by increasing the knowledge and dispelling the myths about the vaccine, and tracking COVID-19 vaccination among the residents and staff by providing in person training with infectious disease experts and provide information in multiple languages.

C. Findings

The consultative services include video montage examples of correct and incorrect behavior, including mask wearing, touching of the face without cleaning hands, failure to socially distance with a focus on when masks are removed (e.g. eating), and hand hygiene. Video reviewers also completed an observation form to track safety metrics over time. Overall, the training and video feedback was been positively received across sites.

There were two vaccine webinars hosted on 12/9/20 and 3/9/21 to provide information and address questions about COVID-19 vaccines. Between the two webinars, we drew over 150 attendees from over 40 nursing homes.

To enable tracking of vaccine uptake by type of healthcare personnel, we created a roster-based tracker. We are using this form to collect point prevalence vaccination coverage among nursing home staff. We assessed point prevalence values at 17 nursing homes with vaccination among staff ranging from 36-100%.

We created vaccine FAQ documents in English and Spanish and continue to update these documents as more updated information becomes available. Finally, we engaged with the CalOptima communications team to provide hot topics and suggested language about COVID vaccines and prevention, to be used in text messaging, flyers, and newsletters, and enable co-branded messaging on the UCI Health website.

Quality of Care Grievances

A. Description:

In 2020, CalOptima received a Corrective Action Plan (CAP) from DHCS. The findings stated that, at a minimum, all Quality of Care (QOC) grievances were to be submitted to a medical director for review and action during the grievance process.

B. Intervention:

In November 2020, QI and GARS implemented a new model for responding to QOC grievances. In this model, the Grievance Resolution Specialist (RS) identifies the QOC grievance and forwards it to the QI RN who performs an Initial Clinical Review to identify any urgent clinical issues that require immediate intervention. At the same time, the RS requests a response from the provider for whom the grievance is regarding. When the response is received, the RS notifies the QI RN who summarizes the case for the medical director. The medical director completes a clinical recommendation which is copied into the Grievance Resolution Letter by the RS and sent to the member within calendar 30 days.

C. Findings:

1. The process change was accepted by DHCS in the CAP response and will be reviewed at the DHCS audit in 2022.
2. The process resulted in a dramatic decline of PQI cases, from an average of 112 per month in 2020 to 16 per month in 2021. Over 95% of the cases referred by GARS in past years were ultimately determined to be Quality of Service, not Quality of Care. The reduction of non-QOC cases has allowed the QI nurses and medical directors to focus on true Potential Quality Issues.

D. Barriers:

Strictly adhering to the referral list may have resulted in a failure to refer to quality of care grievances.

E. Opportunities for Improvement:

Examine complaints related to Access to Care for Quality of Care issues to better identify these types of grievances.

Section 5: 2020–2021 ImproveMENT PROJECTS

The following are a summary of all Quality Improvement Projects (QIP), Chronic Care Improvement Programs (CCIP), Performance Improvement Projects (PIP) and PDSA projects which began or continued through 2020–2021 by each improvement project type.

Quality Improvement Projects (QIPs) – OneCare Connect Population and NCQA Patient Safety Standard – Medi-Cal

1. Improving Statins Use for Patients with Diabetes (SPD) 2019–2022

The improving statin adherence for patients with diabetes mailing intervention targets all three (3) lines of business; Medi-Cal (MC), OneCare (OC) and OneCare Connect (OCC). The Medi-Cal results will be reported to NQQA to satisfy the Patient Safety standard. The OneCare Connect results will be reported to CMS as part of a quality improvement project (QIP). There is no QIP requirement for the OneCare population. However, CalOptima chose to include this small population as part of the SPD intervention.

Goal
To increase statin use among members with diabetes by 5%.

Target Population
All CalOptima members who are diagnosed with diabetes mellitus.

Interventions
A member-focused multi-modal promotion campaign was implemented to reduce cardiovascular risk among CalOptima members diagnosed with diabetes. An SPD member mailing was sent in tandem with an existing provider focused program to promote statin use among members diagnosed with diabetes and to encourage members to have a discussion with their health care providers about whether a statin is right for them.

Activities
Quarterly mailings have been put into place to encourage members to consider the potential benefits of preventing cardiovascular complications.

Mailing Summary: Data collection continues for all three LOB (lines of businesses): Medi-Cal, OneCare and OneCare Connect. Will continue to track and monitor throughout 2021.

SPD Member Quarterly Mailings						
	Q1 2021			Q2 2021		
LOB	Member Count	Members Eligible Sent	Members Received Intervention	Member Count	Members Eligible Sent	Members Received Intervention
OneCare	83	27	17	81	71	18
OCC	657	290	197	562	464	84
Medi-Cal	5347	2183	1348	4780	3947	402
Total	6087	2500	1562	5423	4482	504

Performance Improvement Projects (PIPs)

1. Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)

Goal
To increase the percentage of well-care visits among Medi-Cal members turning 15 months old for Provider Office A, from 39.47% to 44.96% by 12/31/2022. This examines factors such as: provider engagement, data exchange opportunities, provider resources, provider awareness, and appointment availability to see how they directly impact well-care visits.

Target Population
Children assigned to Provider Office A who turn 15 months old during the measurement year.

Intervention
Establish data sharing procedures between the Managed Care Organization (MCO) and the provider office to identify members due for outreach. CalOptima trends rates on a monthly basis and will conduct data exchanges with the provider office quarterly.

2. Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022**)**

Goal
By 12/31/2022, increase the percentage of breast cancer screening among Korean and Chinese Medi-Cal member ages 50-74 from 53.62% to 57.63%.

Target Population
Korean and Chinese CalOptima Medi-Cal members 52-74 years of age as of December 31 of the measurement year. and meet continuous enrollment/allowable gap/anchor date who are eligible to complete a mammogram to screen for breast cancer.

Intervention
CalOptima will conduct a multi-layered member outreach campaign to Korean and Chinese CalOptima Medi-Cal members 52-74 years of age who are eligible to complete a mammogram to screen for breast cancer.

3. **Medi-Cal PIP: Improving Access to Acute/Preventive Care Services to Medi-Cal Members Experiencing Homelessness in Orange County.**

   Goal
   By June 30, 2021, increase the rate of acute and or preventive care services among Medi-Cal members 18 years and older identified as experiencing homelessness in Orange County from 41.8% to 43.2%.

   Interventions
   Implementing Homeless Clinical Access Program (HCAP) to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness.

   DHCS directed CalOptima to close out the PIP projects early due to COVID-19. CalOptima completed up to Module 3 submissions. No interventions were implemented for this PIP project.

CCIPs: OC and OCC and NCQA Emerging Risk Standard – Medi-Cal

Emerging Risk — Improving HbA1c Control <8% for Members Recently Experiencing Poor Control >8% — 2021

Goal: Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1c good control (<8) by conducting proactive outreach to OneCare members with diabetes who were previously <8% but have moved to have an HbA1c ≥8% based on the most recent lab results. The goal is to move 5% of OC members identified and who participate back to an HbA1c <8% within one year.

Target Population: OC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

1. These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
2. Exclusion Criteria:
    a. Ineligible CalOptima members
    b. Members identified for LTC or dementia
    c. Members delegated to Kaiser
    d. Is pregnant
    e. Is currently in palliative care/hospice facility
    f. Was identified as unable to contact by the health coach in the previous outreach list

Interventions: This intervention targets OC members with diabetes with HbA1c results trending upward from <8% to >8%. OC members that had an HbA1c result <8% but now have an HbA1c result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the members on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing HbA1c values <8%.

Summary of Results: Data collection for the intervention started in 2021. See table below:

Emerging Risk Health Coach Telephonic Outreach (OC)

Year	QTR	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached
2021	Q1	OC	5	5	3	0
2021	Q2	OC	5	5	4	1

In Q1 2021, there were 5 OC members that were assigned to a health coach and 3 were successfully outreached telephonically. For Q2 2021, there were 5 OC members that were assigned to a health coach and 4 were successfully outreached telephonically. Will continue to track and monitor throughout 2021.

1. OC CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2021

Goal: Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1c good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an HbA1c ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an HbA1c <8% within one year.

Target Population: OneCare Connect members at risk for poor control >8% who were previously in good control <8% based on recent labs.

1. These members have been enrolled by December 31st of the measurement year and be within 18-75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

Interventions: This intervention targets OCC members with diabetes with HbA1c results trending upward from <8% to >8%. OCC Members that had an HbA1c result <8% but now have an HbA1c result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results: Data collection for the intervention started 2021. See table below:

Emerging Risk Health Coach Telephonic Outreach (OCC)

Year	QTR	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached
2021	Q1	OCC	94	20	10	3
2021	Q2	OCC	108	55	34	3

In Q1 2021, 20 OCC members were assigned to a health coach and 10 were successfully outreached telephonically. In Q2 2021, 55 members were assigned to a health coach and 34 were successfully outreached telephonically. Will continue to track and monitor throughout 2021.

2. OCC CCIP — Emerging Risk – Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2021

Goal

Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1c good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an HbA1c ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an HbA1c <8% within one year.

Target Population

OCC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

1. These members were enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

Interventions

This intervention targets OCC members with diabetes with HbA1c results trending upward from <8% to >8%. OCC Members that had an HbA1c result <8% but now have an HbA1c result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on

areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing HbA1c values <8%.

Summary of Results
Data collection for the intervention started 2021. See table below:
Emerging Risk Health Coach Telephonic Outreach (OCC)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached
2021	Q1	OCC	94	20	10	3
2021	Q2	OCC	108	55	34	3

In Q1 2021, 20 OCC members were assigned to a health coach and 10 were successfully outreached telephonically. In Q2 2021, 55 members were assigned to a health coach and 34 were successfully outreached telephonically. Will continue to track and monitor throughout 2021.

3. Medi-Cal NCQA Standard — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2021

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1c good control (<8) by conducting proactive outreach to Medi-Cal (MC) members with diabetes who were previously <8% but have moved to have an HbA1c ≥8% based on the most recent lab results. The goal is to move 5% of MC members identified and who participate back to an HbA1c <8% within one year.

Target Population
MC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

1. These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

Interventions
This intervention targets MC members with diabetes with HbA1c results trending upward from <8% to >8%. MC members that had an HbA1c result <8% but now have an HbA1c result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing HbA1c values <8%.

Summary of Results
Data collection for the intervention started 2021. See table below:

Emerging Risk Health Coach Telephonic Outreach (Medi-Cal)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached (#5 Yes)	Emerging Risk Members Unsuccessfully Outreached (#5 No)
2021	Q1	Medi-Cal	817	75	47	2
2021	Q2	Medi-Cal	712	148	99	11

In Q1 2021, 75 MC members were assigned to a health coach and 47 were successfully outreached telephonically. In Q2 2021, 148 members were assigned to a health coach and 99 were successfully outreached telephonically. Will continue to track and monitor throughout 2021.

Plan, Do, Study, Act (PDSA)

1. **PDSA – <u>Cervical Cancer Screening Plan, Do, Study, Act</u>**

2021 Cervical Cancer Screening Medi-Cal PDSA Goal:

Measure	2020 PDSA Goal
Cervical Cancer Screening: The percentage of women 21–64 years of age who were screened for cervical cancer	**To increase the number of Medi-Cal members 21-64 years of age who were screened for cervical cancer.**

Background

Every year, the California Department of Healthcare Services (DHCS) establishes minimum performance levels (MPLs) for the Managed Care Accountability Set (MCAS). Plans with measures below the MPL are required to conduct Plan-Do-Study-Act (PDSA). The PDSA methodology is a rapid cycle/continuous Quality Improvement (QI) process designed to perform small tests of change, which allow more flexibility to make adjustments throughout the improvements process. For reporting year (RY) 2020, DHCS required plans to conduct a Plan-Do-Study Act (PDSA) rapid cycle project on a single performance measure of the plan's choice that focused on a preventative care, chronic disease management, or behavioral health MCAS measure impacted by COVID-19.

CalOptima PDSA cycle addressed cervical cancer screening (CCS) among the Medi-Cal members 21-64 years of age. CalOptima anticipated lower screening rates due to the COVID-19 pandemic and therefore focused efforts in trying to sustain and even possibly improve the cervical cancer rates from the previous year. CalOptima had observed a reduction in people accessing health care services, including cancer screenings, due to fear of contracting the COVID-19 virus.

CalOptima collaborated with a health network to identify a provider office with a high volume of Medi-Cal CalOptima members 21-64 years of age that was performing lower in the CCS measure. The PDSA tested member outreach to increase CCS rates among eligible health network members at the targeted provider office site.

Provider Office A's MY2021 rate for the cervical cancer screening (CCS) measure was established as of February 2021 (Table 1). Provider Office A has approximately 27% (N=2762) of the assigned health network CalOptima Medi-Cal members ages 21-64 for CCS measure. The total target population for the PDSA was 1,486. This baseline data was used to compare Provider Office A's CCS measure rate at the end of cycle 1 and cycle 2 after the member outreach intervention.

Table 1: Health Network Provider Office Cervical Cancer Rates for MY2021

Provider Office	MY 2021 Preliminary Rate	Current Den	Current Num	Target Population
Provider Office A	46.2%	2762	1276	1486

Planning

The health network Performance Program Department generated a target list of members due for CCS for the provider office that had been identified. The health network Practice Support Specialist provided the targeted list of members due for CCS to provider the office staff at the beginning of each month. The provider office staff used the targeted list to conduct telephonic outreach to members to schedule CCS appointments. The provider office provided the health network Practice Support Specialist with an outreach tracking log. The tracking log captured the number of members outreached, number of CCS exam appointments made, number of CCS exam no-shows and the number of CCS exams completed. The health network Performance Program sent the tracking log to CalOptima for updates on the CCS completion progress. At the end of Cycle 1 and Cycle 2, the provider office staff was be offered an incentive based on their engagement in the initiative. The engagement is measured by, 1) the provider office sharing a monthly tracking log and outreach goal of 90% of the members in their target list and, 2) the provider office scheduling or completing 10% of the CCS exams from members outreached in cycle 1.

Cycle 1

The SMART AIM for cycle 1 was to outreach to at least 90% (1,337/1486) of members on the target list by May 2021.

Intervention

In February, the health network Support Specialist securely emailed the tracking log to the office Manager of Provider Office A Manager. There was a delay in the initiation of member outreach from February to March. Beginning March, the Provider Office A staff conducted member outreach by sending reminder letters to members from the tracking log. Of the 1478 members, 45 members were removed since they had completed cervical cancer screenings prior to start of this intervention. With the removal of the 45 members, the new denominator was 1433 who were included in the intervention period from March through May 2021.

On a monthly basis the Provider Office A manager securely emailed the updated tracking log to health network Support Specialist and provided any feedback that was relevant to the intervention. The Health Network Support Specialist securely emailed tracking log to CalOptima QA Analyst as well as feedback.

Results

Table 2: Health Network Provider Office Cervical Cancer Screening Outreach by month					
Month	Initial Target List	Prior Completion	New Target List	Count of letters mailed by 5/31/2021	Outreach Rate
March	1478	45	1433	168	11.72%
April	1478	-	1433	95	6.63%
May	1478	-	1433	1123	78.37%
Total	-	-	1433	1386*	96.72%

By May 2021 the Provider Office A staff was able to mail cervical cancer reminder letters to 1,386 members due for cervical cancer screening of 1,433 on the target list with an outreach rate of 96.2%. There was a delay in initiating member outreach from February to March because Provider Office A became a COVID-19 Vaccination site taking away staff resources to initiate member outreach.

Based on the results of the intervention, CalOptima had chosen to adapt the intervention. The intervention completed in cycle 1 focused on Provider Office A staff outreaching to members who were due for cervical cancer screening. Provider Office A still focused on outreaching to members to schedule cervical cancer screenings, but CalOptima plans to add a provider office staff incentive that focused on the number of scheduled or completed cervical cancer screenings.

Cycle 2

The SMART AIM for cycle 2 was to schedule or complete 10% (n=139) of CalOptima eligible Medi-Cal members for cervical cancer screenings that were outreached in cycle 1 (N=1386) by July 16, 2021.

Intervention

In June, the health network Support Specialist securely emailed the updated tracking log to Provider Office A Manager. Provider Office A staff conducted follow-up phone calls to members that were sent reminder letters in cycle 1. Provider Office A staff tracked follow-up phone call outcomes on tracking log as well as members that were scheduled or completed CCS. There were 1386 members that were sent the reminder letters in cycle 1 and would be able to receive a follow-up phone call.

On a monthly basis the Provider Office A manager securely emailed the updated tracking log to the Provider Support Specialist and added any feedback that was relevant to the intervention. The provider Support Specialist then securely emailed the tracking log to CalOptima QA Analyst.

Results

Table 3: Health Network Provider Office A Cervical Screening Follow-Up Phone Call Outcomes	
Follow-up Phone Call Outcome	Count
Completed	47
Pt sees different provider	3
Other (Add Notes): Excluded from measure	2
Left Voicemail	150
Other (Add notes): Moved out of state	1

No Answer	11
No Follow-Up Call	1029
No Phone # on file for pt	6
Pt requests referral to specialist	1
Pt refused	18
Requested a Call Back	33
Pt Scheduled	65
Pt termed	3
Wrong # for pt on file	17
Total	**1386**

The total number of members that received a follow-up phone call were 357 out of 1386 members who were mailed a reminder letter in cycle 1. For this intervention 47 members completed cervical a cancer screening and 65 were scheduled for a cervical cancer screening for a total of 112. The results for this intervention indicated that 8.08% (112/1386) of members that were sent a reminder letter in cycle 1 either scheduled or completed a cervical cancer screening in cycle 2. Therefore, the SMART objective goal was not reached.

Provider Office A staff only had the opportunity to attempt one follow-up phone call to members that were mailed reminder letters for cervical a cancer screening in cycle 1. Due to the short duration of cycle 2, there were 1,029 members that did not receive a follow-up phone call.

Based on the results of the intervention, CalOptima chose to adopt the intervention. CalOptima and the health network will identify other provider offices that have high volume of Medi-Cal CalOptima members due for cervical cancer screening (CCS) and low performing for the CCS measure. The Health Network Performance Program Department will generate a target list of members due for CCS for other provider offices that will be identified.

2021-2022 COVID-19 QIP Proposal- Pending Approval

Each measure in QIP proposal will be evaluating the impact of COVID-19 upon the measure.

Strategy 1: Behavioral Health

1. **Strategy:**
    a. Increase the number of diabetes screenings for members on antipsychotic medication.
    b. Identify members still in need of diabetes screening for the year and notify prescribing provider of (a) members in need of diabetes screening (b) best practice guidelines (c) primary care physician (PCP) name and contact information for each member (to promote coordination of care).
    c. Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening for providers to contact members via phone; (b) best practice guidelines reminder; and (c) primary care physician (PCP) name and contact information for each member (to promote coordination of care by requesting prescribers to contact the PCP with lab results).
    d. Plan to monitor monthly prospective rates to evaluate progress.

2. **Targeted MCAS measure:** Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
3. **Targeted Population:** All
4. **Rationale:** SSD did not meet the MPL for MY 2020. Due to the impact of the pandemic (e.g., stay-at-home orders), individuals may have been less likely to attend routine or follow-up appointments and take care of certain recommendations by their providers (i.e., lab work requests). Identified 1,234 members still in need of screenings this year.

Strategy 2: Women's Health

1. **Strategy:** Increase the number of Medi-Cal members 21-64 years of age who were screened for cervical cancer.
    a. The intervention will test member outreach via letter reminders and/or phone call reminders to increase CCS rates among eligible HN CalOptima ages 21-64 members at the targeted provider office sites. Member outreach modality will be chosen by each provider office site based on staff resources.
    b. CalOptima and HN have identified provider offices that have high volume of CalOptima Medi-Cal members due for cervical cancer screening (CCS) and low performing for the CCS measure.
    c. Identified 4 HN provider offices with a combined CCS denominator of 5,111 members. The target outreach population for this intervention is 2,619. This represents the HN CalOptima members ages 21-64 who are due to complete cervical cancer screening.
2. **Targeted MCAS measure:** Cervical Cancer Screening (CCS)
3. **Targeted Population:** Multiple; Medi-Cal members ages 21-64 years who need a cervical cancer screening
4. **Rationale:** CalOptima and HN have identified provider offices that have high volume of CalOptima Medi-Cal members due for cervical cancer screening (CCS) and low performing for the CCS measure.
5. **Next steps:** Reach out to the identified provider offices if interested in participating in member outreach intervention to increase cervical cancer screening. CalOptima will be providing a provider office staff incentive based on process measure and outcome measure.

Strategy 3: Child and Adolescent Health

1. **Strategy:** Increase the immunization rates of Medi-Cal members turning 2 years of age who are due for vaccinations.
    a. CalOptima has identified provider offices that have high volume of CalOptima Medi-Cal members due for childhood vaccinations and low performing for the CIS-Combo 10 measure. Vaccinations include: DTP, FLU, HEP, HEPA, HIB, MMR, PCV, PV, ROTA, VZV
    b. The intervention will include provider office outreaching to noncompliant members via phone to help increase compliance. Using target list provided by CalOptima, the provider office is expected to outreach to members, educate members on the importance of vaccinations, schedule appointment(s), and complete visits/vaccinations. These efforts will be measured and equate to the provider office staff incentive. The provider office staff incentive tier payment

system will be based on operational and performance metrics as established by CalOptima.

1. **Targeted MCAS measure:** Childhood Immunization Status (CIS Combo 10)
2. **Targeted Population:** Multiple; all members ages 0-2 years old who are assigned to partnering provider office.
3. **Rationale:** Immunizations continue to be high priority especially with the impact of COVID-19 pandemic delaying office visits due to hesitancy and scheduling. CalOptima has identified provider offices that have high volume of CalOptima Medi-Cal members due for childhood vaccinations and low performing for the CIS-Combo 10 measure. Vaccinations include: DTP, FLU, HEP, HEPA, HIB, MMR, PCV, PV, ROTA, VZV.
4. **Next steps:** Outreach to identified provider office to solicit interest in participating in member outreach intervention to increase childhood immunizations. CalOptima will provide an office staff incentive based on process measure and outcome measure.
    a. After outreaching to offices to partner, South Coast Pediatrics (SCP) agreed to collaborate on this QIP. SCP has 663 Medi-Cal members who fall in the CIS-Combo 10 denominator for MY 2021. The target outreach population is: 611 members. There current CIS-Combo 10 rate is 7.84% based on claims and encounters processed through August 2021. The NCQA 50th Percentile Benchmark (MPL) for CIS-10 is 38.20%.

2021 Oversight of QIPE/PPME Dashboard for OC and OCC

OC

1. HRA initial and annual outreach completed to date for 2021 between 98%–100%
2. HN Model of Care oversight 100% for all quarters to date.

OCC

1. HRA initial and annual outreach completed to date for 2021 between 98%–100%
2. CA 1.5 high risk members with an ICP completed Q1 63%, Q2 63%, Q3 65%
3. CA 1.5 low risk members with an ICP completed Q1 49%, Q2 50%, Q3 51%
    a. There is expected improvement for both high and low risk completion rates based on recent clarifications from DHCS.
4. CA 1.6 Members with ICP with documented discussion of care goals. Q1 92%, Q2 93%, Q3 89%

ICP completed in 90 days: CalOptima has maintained high rate for ICP completion within 90 days of eligibility as seen in our 3.2 MMP reporting. Quarter 1 reporting demonstrated a rate of 86 %; Quarter 2 reporting reflected rate of 87%; and, Q3 results show 89% completion. This success is based on processes that were implemented in 2020. ICP completion in 90 days is a withhold measure. 2021, DY 7 has benchmark of 85% completion rate for 3.2 MMP reporting. CalOptima is on track to achieve this benchmark.

Overall Effectiveness and Opportunities

In conclusion, CalOptima's 2021 QI Program Evaluation findings inform the 2022 QI Work Plan. Key issues and improvement opportunities are monitored routinely to ensure that adequate input is received and implemented on a regular basis.

The mission of CalOptima is, "To provide members with access to quality health care services delivered in a cost-effective and compassionate manner." CalOptima's Quality Management Program leads us toward this goal while focusing on quality initiatives that can be most impactful.

~~2021~~2022

QUALITY IMPROVEMENT PROGRAM

~~2021~~2022 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard ~~Emily Fonda~~Pitts, D.O., Ph.D. **Date**
~~Interim~~ Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

~~Mary Giammona~~Trieu Tran, M.D. **Date**

Board of Directors Chair:

Supervisor Andrew Do **Date**

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WE ARE CALOPTIMA

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

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason 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. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.

- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

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

Stewardship

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

We are "Better. Together."

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

Our Strategic Plan

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

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

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

As both, CalOptima must:

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

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. CalOptima marked 25 years of service to Orange County's Medi-Cal population in 2020.

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, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

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

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA)
- Substance use disorder services are administered by HCA
- Dental services are provided through ~~California's Denti-Cal~~the Medi-Cal Dental Program

Members With Special Health Care Needs

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

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as

special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA 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.

OneCare provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality 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 individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

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

Scope of Services

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

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) 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 frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits and an out-of-the-country urgent/emergency care 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.

OneCare Connect 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 individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

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

The Cal MediConnect demonstration program is ending in 2022, and CalOptima is planning to transition OCC members to OC, effective January 1, 2023.

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 care, preventive care and behavioral health services covered under Medi-Cal and Medicare. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits and over-the-counter benefits ~~and transportation~~. OCC also includes personalized services through the PCCs to ensure each member receives the services they need when they need them.

~~**In 2022, transition plans will be in process for OCC programs to sunset by 12/31/2022, and transition all members to the OneCare programs.**~~

~~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, dietitians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services – other than emergency care – from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.~~

PROGRAM INITIATIVES

Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a public health emergency (PHE) that has changed the landscape of delivering quality health care to our members. The ~~2021~~2022 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity have existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in ~~October 2020~~September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths, but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as part of the QI Work Plan. ~~Additionally, the COVID-19 pandemic adversely impacted the mental health of many members, especially children. Hence, several trauma-informed interventions are included in the 2021~~2022 ~~QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 pandemic.~~

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

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

Quality Strategy Goals

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

Quality Strategy Guiding Principles

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

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

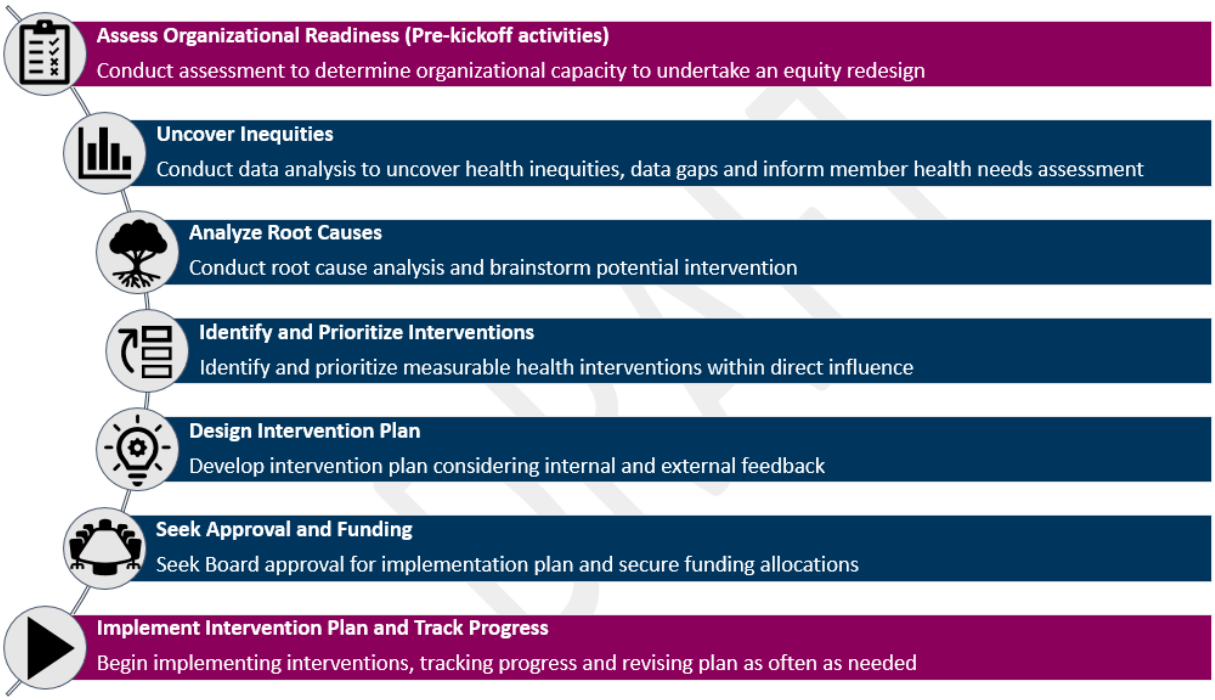
- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

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

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

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



California Advancing and Innovating Medi-Cal (CalAIM)

~~Whole Person Care~~

~~Whole Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information-sharing platform was launched in November 2018. WPC is scheduled to terminate on December 31, 2020; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicaid Services (CMS) extend the pilot for an additional year.~~

~~Whole Child Model~~

~~California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with HCA.~~

~~Health Homes Program~~

~~The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the~~

~~"Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.~~

~~CalOptima implemented HHP in two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD); and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During implementation, HHP targeted the highest risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:~~

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

~~Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:~~

1. ~~Comprehensive care management~~
2. ~~Care coordination~~
3. ~~Comprehensive transitional care~~
4. ~~Health promotion~~
5. ~~Individual and family support services~~
6. ~~Referral to community and social support services~~

~~CalOptima will provide housing-related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC program, who are also eligible for the HHP, to continue with their current WPC providers for their housing-related services.~~

~~Homeless Health Initiative (HHI)~~

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

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

- ~~Recuperative Care — As part of the Whole Person Care program, recuperative care services provide post-acute care for up to 90 days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing~~

~~participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with the Whole Person Care program, and the CalOptima Board of Directors has authorized the extension of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.~~

- ~~Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to HCA to provide additional respite care beyond the 90 days of recuperative care under the Whole-Person Care program. These grant funds have been exhausted.~~

- ~~Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), HCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 pandemic, these services are available via telehealth, in addition to in person.~~

  ~~Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. Through this program, CalOptima provides preventive screenings, chronic care, care coordination and follow up.~~

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

  California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the ~~our~~Medi-Cal population by implementing broad delivery system, ~~as well as~~ program and payment reforms ~~across Medi-Cal~~.

  CalAIM has three primary goals:

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

Enhanced Care Management and Community Supports

Beginning on January 1, 2022, CalOptima ~~will~~ implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management ~~ECM~~ provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services ~~which~~that addresses the member's complex medical and social needs. Community Supports ~~provide a~~are alternatives to covered services, which are provided to reduce or avoid admissions to ~~substitute to, or to avoid, other covered services, such as~~ a hospital or skilled nursing facility admission, emergency department visits and ~~of a~~ discharge delays.

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

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

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

- Members experiencing homelessness (adults and children)
- High utilizer adults
- Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)

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

~~Health Homes Program and Whole-Person Care~~~~HHP~~HHP and WPC service providers will continue to provide services under Community Supports as CalOptima works to expand ~~its~~the network of Community Supports providers that have the expertise and capacity to provide the specific types of services~~, as needed~~. Members eligible for Community Services must consent to participate and receive services. Community Support services include the following:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)

12. Medically tailored meals/medically supportive foods
13. Sobering centers
14. Asthma remediation

Beginning January 1, 2022, CalOptima ~~will~~ offers the following four~~, distinct~~ Community Supports services:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Recuperative care (medical respite)

CalOptima will continue to assess the needs the of members and collaborate with community stakeholders to add new Community Supports.

2021 ~~20~~22 ~~CCN~~CalOptima Community Network (CCN) Pilot Program

Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members With Poorly Controlled Diabetics

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

1. Pharmacist Involvement and Intervention:
   CalOptima pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptima believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with primary care providers (PCPs) and health coaches/registered dietitians/case managers.
2. Health Coach/Registered Dietitian Management Intervention:
   CalOptima health coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials and referral to other community resources based on needs. Health coaches/registered dietitians ~~would~~will also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.
3. Non-Monetary Member Incentives:
   CalOptima would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.
4. Provider Incentives:
   In order to have successful provider ~~buy-in~~support, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary ~~DM~~diabetes program. Providers are eligible for incentives when they ~~participate in the program to~~ manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

Pharmacy Administration Changes

Effective January 1, 2022 ~~April 1, 2021~~, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for Medi-Cal only and does not affect OC, OCC or PACE.

~~Virtual Care Strategy~~

With Whom We Work

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~~CalOptima members. Providers can ~~participate~~ contract through CalOptima Direct, CalOptima Direct-Administrative and/or CalOptima Community Network (CCN) and/or contract with a CalOptima HN. CalOptima members can choose CCN or one of 12 HNs representing more than ~~8,5~~9,400 practitioners.

CalOptima Direct (COD)

CalOptima Direct has two elements: CalOptima Direct-Administrative and CCN.

- CalOptima Direct-Administrative (COD-A)

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

- CalOptima Community Network (CCN)

  ~~The CalOptima Community Network provides~~CCN doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks

CalOptima has contracts with delegated HNs through a variety of ~~HN financial~~ risk models to provide care to members. The following contract risk models are currently in places~~. Since 2008, CalOptima's HNs consist of~~:

- Health Maintenance Organization (HMO)

- Physician/Hospital Consortia (PHC)
- Shared-Risk ~~Risk~~ ~~Medical~~ Groups (SRG)

Through our~~the~~ delegated ~~se~~ HNs, CalOptima members have access to more than~~nearly~~ 1,~~600~~ 500 ~~primary care providers (~~PCPs~~)~~, more than ~~86,800~~ ~~6~~7,900 specialists, 40 acute and rehabilitative hospitals, ~~35~~ 31 ~~clinics~~ community health centers and nearly 100~~100~~ long-term care facilities.

CalOptima contracts with the following HNs:

Health Network~~/Delegate~~	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
~~AMVI/Prospect Medical Group~~		~~SRG~~	
AMVI Care Health Network	PHC	-	PHC
~~Optum Care Network - Arta Western Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~
AMVI/Prospect ~~Health Network~~Medical Group	-	SRG	-
CHOC Health Alliance	PHC	-	-
~~Family Choice Health Network~~	~~PHC~~		
Family Choice Medical Group	PHC	SRG	~~SRG~~~~PHC~~SRG
HPN-Regal Medical Group	HMO	-	HMO
Kaiser ~~Permanente~~~~Foundation Health Plan~~Permanente	HMO	-	-
Noble Mid-Orange County~~Optum Care Network - Monarch HealthCare~~	SRG~~HMO~~	SRG~~SRG~~	SRG~~HMO~~
~~Monarch Health Plan, Inc.~~	~~HMO~~		~~HMO~~
Optum Care Network - Arta	SRG	SRG	SRG
Optum Care Network - Monarch	HMO	SRG	HMO

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

Delegate	Medi-Cal	OneCare	OneCare Connect
Vision Service Plan	VS	VS	VS

HMO=Health Maintenance Organization
PHC=Physician-Hospital Consortium
SRG=Shared Risk Group
VS=Vision Service

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

- Utilization management
- Basic and complex case ~~Case m~~Management ~~and Complex Case Management~~
- Claims~~(professional and institutional)~~
- Contracting
- Credentialing of practitioners
- Customer service ~~activities~~

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2022

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

Membership Data from December 31, 2021, Financial Information

Total CalOptima Membership
870,489

Program	Members
Medi-Cal*	852,805
OneCare Connect	14,933
OneCare (HMO SNP)	2,330
Program of All-Inclusive Care for the Elderly (PACE)	421

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

Member Age (All Programs)

9%	0 to 5
27%	6 to 18
33%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

59%	English
26%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

41%	Temporary Assistance for Needy Families
35%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
5%	People with Disabilities
<1%	Long-Term Care
<1%	Other

Financial Information FY 2021–22 Budget

Program	Annual Budgeted Revenue	% Total Budgeted Revenue
Medi-Cal	$3,249,878,660	88.89%
OneCare Connect	$339,332,450	9.28%
OneCare	$25,409,771	0.69%
PACE	$40,274,039	1.10%
MSSP**	$1,218,536	0.03%

Note: Fiscal Year 2021–22 Operating Budget began on July 1, 2021.
** Multipurpose Senior Services Program (MSSP)

Total Budgeted Annual Revenue
$3.7 billion

CalOptima spends nearly 96 cents of every dollar on member care.

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2021

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

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service 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 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 primary care, urgent care, acute and subacute care to long-term ~~care~~care~~, to~~ and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, ~~disabilities~~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 or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

~~Since 2010, the "Triple Aim" has been at the heart of the 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.~~CalOptima is committed to promoting diversity in practices throughout the organization, including HR best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

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 ~~health networks~~HNs. Through the QI Program — and in collaboration with ~~its~~ providers and community partners — CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the 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 agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

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

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management and support processes.
- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensuring certain contracted facilities report to the public health authority (HCA) outbreaks of conditions and/or diseases ~~to the public health authority (HCA)~~, which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.
- Promoting ~~patient~~ member safety and minimizing risk through the implementation of ~~patient~~ safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners,

provider medical groups and other related organizational providers (~~OPS~~OPs) to assure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance ~~Internal and External~~ Audit & Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD network providers serving CalOptima's various populations:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- Timely identify 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
- Ensure 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
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances
- Ensure the reliability of risk prevention and risk management processes
- Ensure compliance with regulatory agencies and accreditation standards
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans
- Promote the effectiveness and efficiency of internal operations
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs

- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values

- Ensure 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 described 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 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 approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, 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 conduct annual evaluation, provide strategic direction and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim (which expands on 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~~has 15 voting members, with each seat ~~represents~~ representing 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~~Program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a ~~bimonthly~~ monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership ~~is composed of~~includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- ~~Medically indigent persons~~ Medical safety net
- ~~Orange County~~County of Orange Social Services Agency (OC SSA)
- Persons with disabilities
- ~~Persons with mental illnesses~~
- Persons with special needs ~~— behavioral/mental health~~
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by 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. The OCC MAC ~~is comprised of~~has 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the ~~implementation of the~~ program.

The OCC MAC membership ~~is comprised of~~includes 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
- In-Home Supportive Services (IHSS) provider or union representative
- LTC facility representative

- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA Behavioral Health
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - 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 bimonthly meetings ~~are held at least quarterly and~~ are open to the public.

Provider Advisory Committee

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

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- ~~Traditional~~ Safety net ~~provider~~
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC ~~is composed of~~includes the following 11 voting seats:

- Family representatives (seven ~~to nine~~ 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 current recipients of CCS services; or
- Current CalOptima members over the age of 21 who transitioned from CCS services

- Interests of children representatives (~~: two-to-four~~four seats)
  - Community-based organizations; or
  - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC meets bimonthly~~at least quarterly~~, and 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 Information Officer (CIO) provides oversight of CalOptima's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the agency's risk exposure.

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

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI ~~program~~ Program 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.

~~**Deputy Chief**~~ **Deputy Chief Medical Officer** (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO collaborates with directors and medical directors in the operational oversight of the medical division, including Quality Improvement, ~~Medical Data Management~~Quality Analytics, Utilization Management, Case Management, Population Health Management, Pharmacy Management, ~~Long Term Care~~LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. COS ~~Carpenter~~ is

responsible for achieving operational efficiencies to support CalOptima's strategic plan, goals and objectives.

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

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the physician designee who ~~the~~ chairs ~~of~~ the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care physician~~practitioner~~ in the QI ~~program~~ Program who serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC) and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Executive Director, Quality & Population Health Management (ED Q&PHM) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan ~~with NCQA.~~. The ED Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ~~ED~~Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and ~~integrating~~ integrate behavioral health across the ~~health care~~ delivery system and populations served. Reporting to the ED Q&PHM are the directors of Quality Analytics, Quality Improvement and Population Health Management~~Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.~~.

Executive Director, Behavioral Health Integration (ED BH) is responsible for oversight of CalOptima's Behavioral Health (BH) program including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Clinical Operations (ED 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 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, Program Implementation (ED PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED PI ~~are~~ is the director of ~~both~~ Process Excellence ~~and Strategic Development~~.

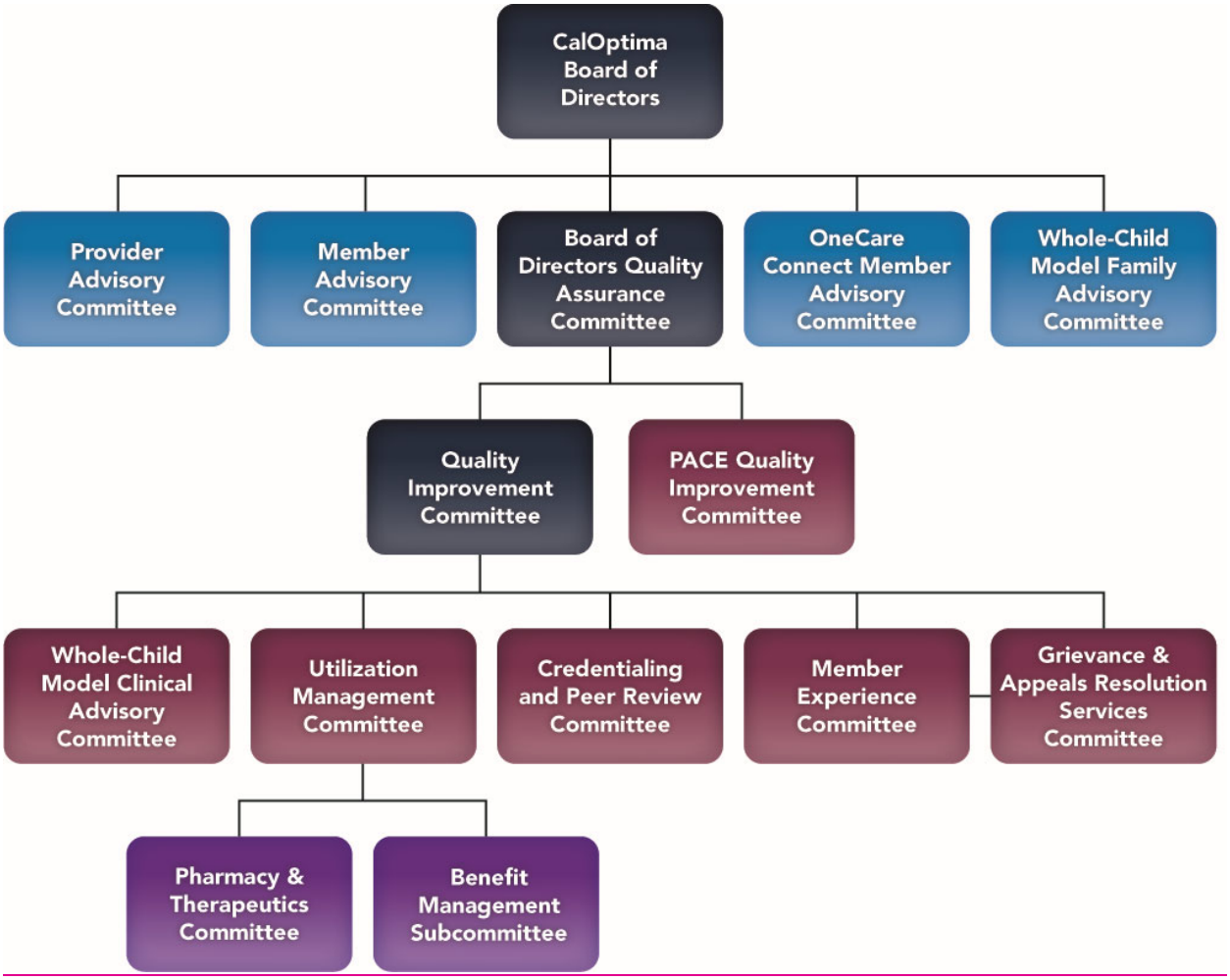
Executive Director, Public Affairs (ED PA) is responsible for CalOptima's Communications, Government Affairs, Community Relations and Strategic Development departments. ED PA is charged with assisting the CEO in carrying out organizational goals, including overseeing the development of the CalOptima Strategic Plan and implementation of communications strategies to highlight CalOptima programs and priorities. Under ED PA's leadership, the Public Affairs team members collaborate on efforts that support the CalOptima mission and reach internal and external audiences, ranging from employees and members to government officials and the media. Reporting to ED PA are the directors of both Communications and Strategic Development.

Executive Director, Compliance (ED C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the ~~CalOptima~~ Audit & Oversight department~~s (external and internal)~~ to refer any potential ~~sustained~~ noncompliance issues or trends encountered during audits of HNs and other functional areas. The ED C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED C 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 NO) leads and directs the integrated operations of the HNs and ~~must~~ coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED 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 and quality health care services is maintained throughout the service delivery network.

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

Committee Organization Structure — Diagram



QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI ~~program~~ 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 delegated ~~health networks~~HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIC oversees the performance of delegated functions by monitoring ~~its~~ delegated ~~health networks~~HNs and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to CalOptima, including a 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, 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:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives
- Overseeing the analysis and evaluation of QI activities
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI ~~program~~ Program activities
- Identifying and prioritizing needed actions and interventions to improve quality
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions

Practice patterns of providers, practitioners and delegated ~~health networks~~HNs are evaluated, such as UM over/under utilization in collaboration with applied behavioral analysis utilization. Recommendations are made to promote practices that all members receive medical and behavioral health 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~~ 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, and delegated ~~health networks~~HNs.

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

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data 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:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima ~~CMO~~ Chief Medical Officer (Chair or Designee)

- CalOptima Medical Directors
- CalOptima Behavioral Health Integration~~BH~~ Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four 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~~QIC 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 QIC 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 produced only for committee approval.

Credentialing and 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 who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers, delegated ~~health networks~~HNs and OPs to ensure ~~patient~~ member safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or physician 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.

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 medical, behavioral health and ~~Long-Term Services and Support (~~LTSS services for ~~the CalOptima Care Network (~~CCN and through the delegated ~~health networks~~HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity 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. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. 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) ~~(P&T)~~

The P&T ~~committee~~ is a forum for an evidence-based formulary review process. The P&T ~~committee~~ promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members. ~~, and~~It reviews ~~anticipated~~anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T ~~committee~~ 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 ~~committee~~ 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 ~~committee~~ provides written decisions regarding all formulary development decisions and revisions. The P&T ~~committee~~ meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T ~~committee~~ 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 lines of business~~ benefits, prior authorization and financial responsibility requirements ~~for the administration of benefits~~. The ~~subcommittee~~ BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance 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.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

~~The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-023.~~ The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima WCM program. The WCM CAC works in collaboration with county CCS, the WCM ~~Family Advisory Committee~~FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee 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's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's Consumer Assessment of Healthcare Providers and Systems (CAHPS)~~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 "pain points" in health care that impact our members at the plan and ~~health network~~HN level (including CCN), where appropriate. In ~~2021~~2022, the MEMX committee, which includes the Access and Availability

workgroup, will continue to meet at least quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY ~~2021~~ 2022 and MY ~~2022~~ 2023 CAHPS survey results.

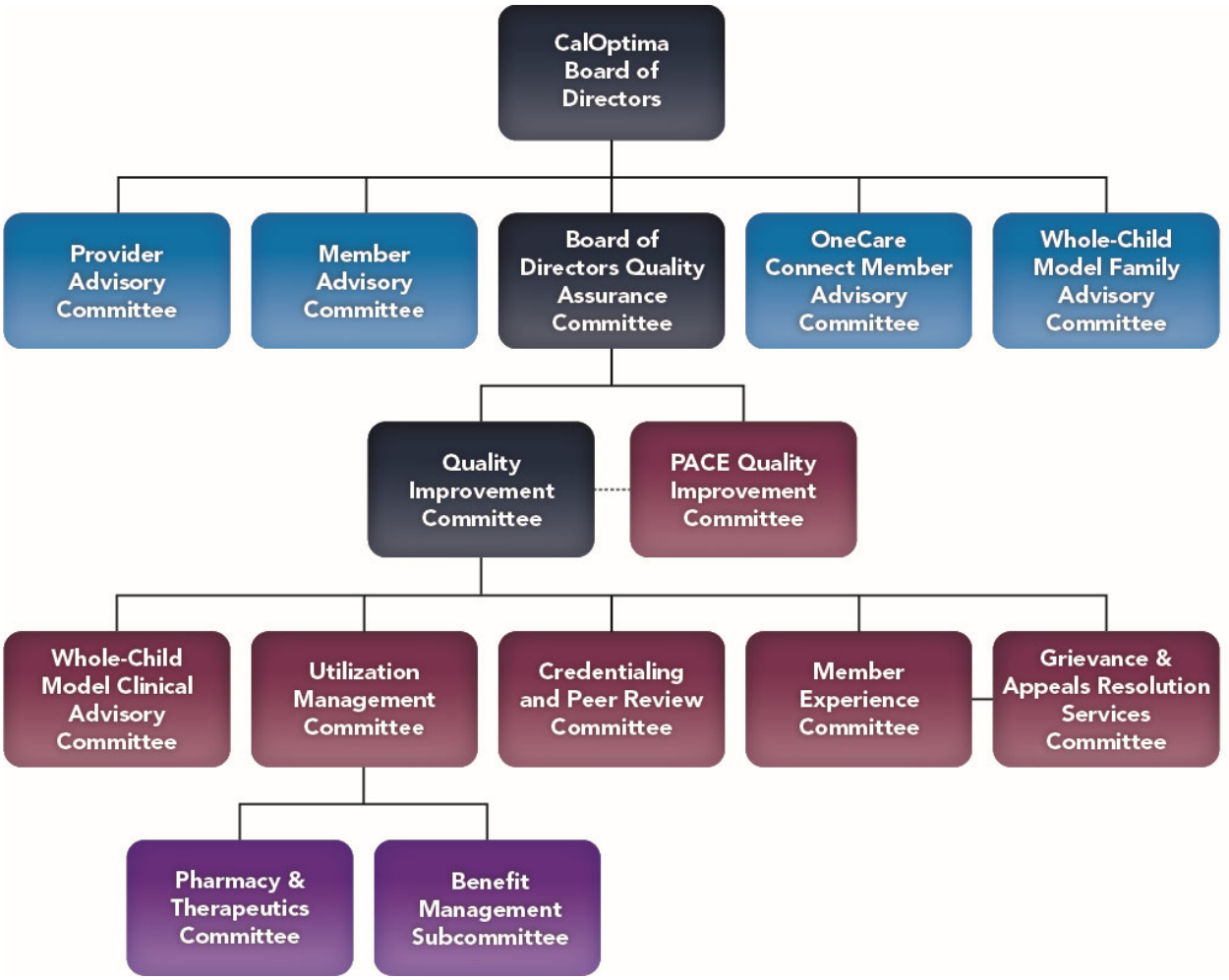
Grievance and Appeals Resolution Services (GARS) Committee ~~(GARS)~~

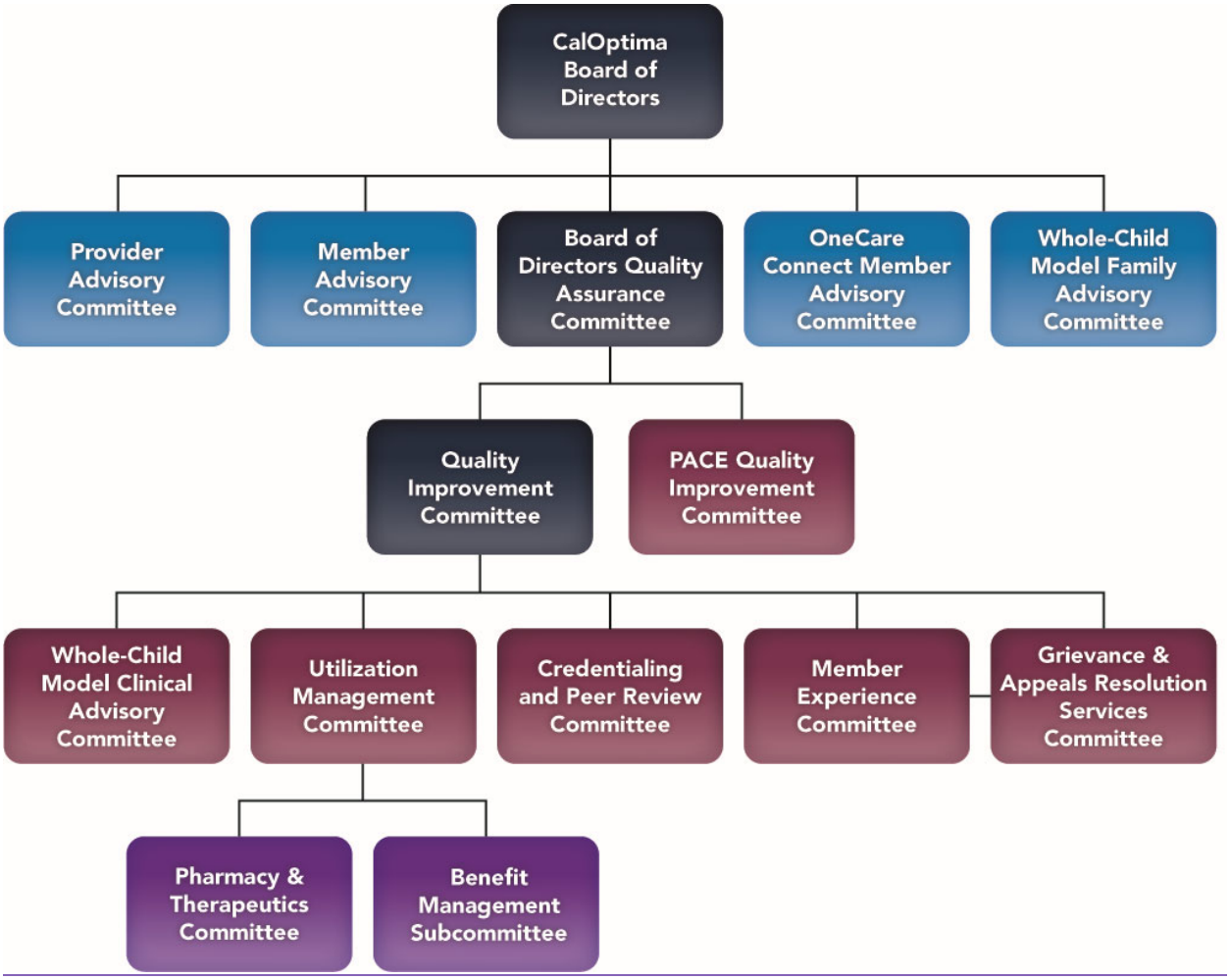
The GARS ~~committee~~ Committee serves to protect the rights of ~~our~~ members, promote the provision of quality health care services and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS ~~committee~~ 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~~ Committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

~~Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)~~

~~The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC), which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement 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. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.~~

~~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.

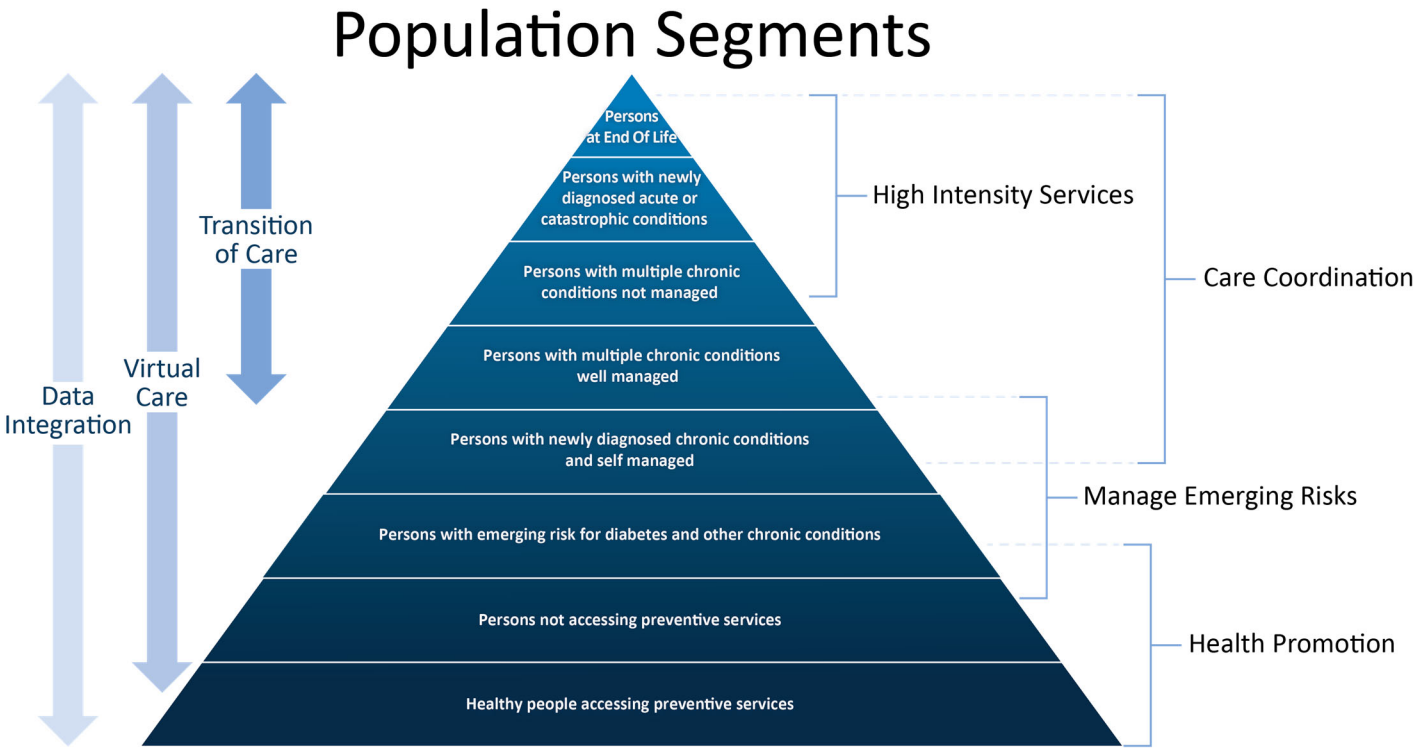
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee 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 and structure provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by stratifying the 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 (MOC), the ~~2021~~2022 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 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 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.

~~2021~~2022 QI Goals and Objectives

CalOptima's QI Goals and O~~o~~bjectives are aligned with CalOptima's ~~2021~~2022 ~~2022~~ ~~20~~23 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
~~1) Support our alignment with Department of Health Care Services by…Health Equity~~
~~1)~~ ~~2)~~ Ensure member's safety during COVID-19 pandemic by a~~A~~iming for ~~9~~80% COVID-19 vaccine rate or community immunity~~, as a stretch goal to ensure member's safety during COVID-19 pandemic.~~
2)
3) ~~2)~~ Improve quality of care and member experience by m~~M~~aintaining NCQA Health Plan Rating of 4.0, and at least a ~~3~~Three-Star Rating for Medicare.

~~1.~~ ~~3) a.~~ Engage providers through the provision of new Pay for Value (P4V) program for Medi-Cal and the new OneCare programs through ~~Develop and receive Board of Directors approval for a new P4V program for new OneCare program to~~ incentivize measures related to our STAR rating~~Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during COVID-19 pandemic.~~

~~2. Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.~~

~~3.~~4) ~~Achieve Accredited NCQA status post 2021 Renewal Survey, and maintain NCQA overall rating at 4.0~~

These top ~~three~~ four priority goals were chosen to be aligned with CalOptima's strategic objectives, ~~related to~~ the pandemic, as well as continued goals related to access to care and NCQA accreditation. The ~~2021~~2022 QI Workplan details the planned activities to meet the COVID-19 vaccine aim, which include ~~an~~ strategies for immunization ~~strategy~~, ~~a~~ targeted communication ~~strategy~~ and a member incentive ~~strategy~~. The planned activities related to members' ability to access care are captured ~~in the Virtual Care strategy, as well~~ as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). ~~Finally, the goal of achieving NCQA - Accredited status in 2021 and maintain overall health plan rating is high priority since CalOptima will be~~is pursing re-accreditation in July of 2021. All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for ~~the OneCare and OneCare Connect programs~~OC and OCC. 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
- Assuring proper identification of ~~Social Determinants of Health (SDOC)~~SDOH
- 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~~ the 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. A QI Work Plan addendum 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 CalOptima strategic priorities and the most recent and trended HEDIS, ~~Consumer Assessment of Healthcare Providers and 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
- 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 CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual ~~patient~~ care aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the ~~2021~~2022 QI Work Plan.

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 — ~~2021~~2022 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 issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience 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,~~LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for ~~SPD~~Seniors and Persons with Disabilities (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 occurs at all levels of the organization.

- Individuals and administrators initiate improvement projects within their area of authority that 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, delegated HN, 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.

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%–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 tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depending on the type of opportunity for improvement identified. The ~~Plan/Do/Study/Act~~PDSA 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

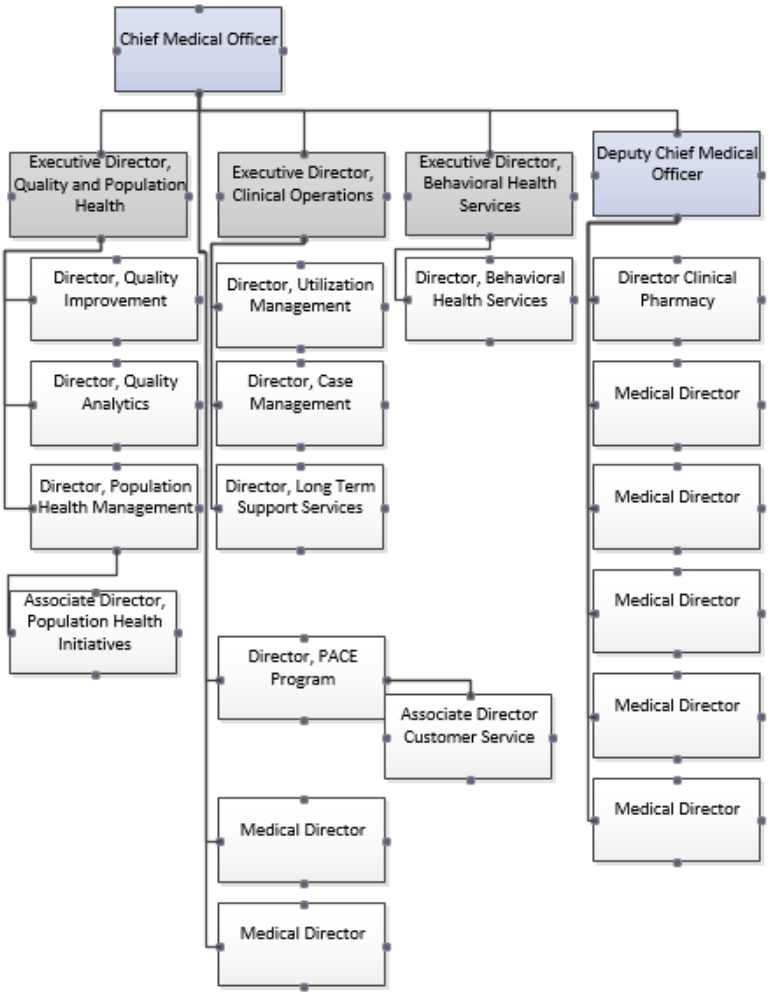
Communication of QI Activities

Results of performance improvement and collaborative 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 ~~Quality Assurance Committee~~QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. 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~~ medical ~~Directors~~ directors' meetings, Quality Forums and other ongoing ad hoc meetings
- ~~Annual synopsized QI report is posted on CalOptima's website (both website and hard copy are available for both practitioners and members). The information includes a QI Program Executive Summary and 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 CalOptima's website, and is made available upon request~~

- MAC, OCC MAC, WCM FAC and PAC~~.~~

QUALITY PROGRAM ORGANIZATION STRUCTURE - DIAGRAM


Chief Medical Officer
Executive Director, Quality and Population Health
Executive Director, Clinical Operations
Executive Director, Behavioral Health Services
Deputy Chief Medical Officer
Director, Quality Improvement
Director, Quality Analytics
Director, Population Health Management
Associate Director, Population Health Initiatives
Director, Utilization Management
Director, Case Management
Director, Long Term Support Services
Director, PACE Program
Associate Director Customer Service
Medical Director
Medical Director
Director, Behavioral Health Services
Director Clinical Pharmacy
Medical Director
Medical Director
Medical Director
Medical Director
Medical Director

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, ~~IS~~ Information Technology Services 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's CMO and ED, 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 Quality Management ~~(QM)~~ functions, including credentialing, ~~Facility facility Site site Reviews~~review FSRs, ~~Physical~~ physical ~~Accessibility~~ accessibility ~~Compliance~~ compliance and working with the ED, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement
- Supervisor, Quality Improvement (PQI)
- Supervisor, Quality Improvement (Nursing Facilities) ~~and Master Trainer (FSR)~~ (CBAS) (FSR)
- Supervisor, Quality Improvement (Credentialing)
- QI Nurse Specialists (RN) (LVN)
- Program Policy Analyst
- Credentialing Coordinators
- Program Specialists (including Intermediate and Senior)
- Program Assistants
- Outreach Specialists
- Auditors

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. 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 (HEDIS)
- ~~Quality Analytics Pay for Value~~ Manager, Quality Analytics (Pay for Value)
- ~~Quality Analytics Network Adequacy~~ Manager, Quality Analytics (Network Adequacy)
- ~~Quality Analytics Data Analytics~~ Manager, Quality Analytics (Data Analytics)

- ~~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 agencywide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy Management 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:
- Associate Director, Population Health Initiatives
- Population Health Management Manager (Quality Initiatives)
- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Supervisors
- Program Managers
- Health Coaches
- Registered Dieticians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants
- ~~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 Dietitians~~
- ~~Data Analyst~~
- ~~Program Manager~~
- ~~Program Specialists~~
- ~~Program Assistant~~

Director, Behavioral Health Integration
Provides program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is

responsible for the management and strategic direction of the Behavioral Health Integration department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

~~**Director, Behavioral Health Services (Clinical Operations)**~~

~~Provides clinical operational oversight and leadership to the implementation, expansion and/or improvement of processes and services of the Behavioral Health Integration department clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and UM for members in all lines of business.~~

~~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~~ UM committees and participates in the QIC and the ~~Benefit Management subcommittee~~BMSC.

Director, Clinical Pharmacy Management

Leads the development and implementation of the Pharmacy Management ~~(PM)~~ program, develops and implements ~~PM~~ Pharmacy Management 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~~P&T and UMC ~~cCommittees~~. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management

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 (LTSS)

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 road map for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the road map. 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 respective 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~~ fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training

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.

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.

Annual Program Evaluation ~~*G:\QIC\QAC Holding Folder\2022_03-09 (Due 02.11.22)\QI Report*~~

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected ~~on~~ in the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are 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 toward 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 QI activities, including QIPs, PIPs, PDSAs and CCIPs

- 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 d~~Diagnosis, care and treatment of acute and chronic conditions

- Complex case management: ~~CalOptima coordinates services for~~For members with multiple and/or complex conditions to obtain access to care and services via the ~~Utilization~~ UM and Case Management departments~~, which details this process in its UM and CM Programs and other related policies and procedures.~~
- Drug utilization
- Health education and promotion
- Over/underutilization
- 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 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 ensure 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~~and agencywide
- Evaluate and monitor provider credentials

- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain agencywide practices that support accreditation and meet 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 potential quality of care cases are reviewed by a medical ~~Director~~ director who determines a proposed action, dependent on the severity of the case. The ~~Medical~~ medical ~~Director~~ director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy or GARS, as well as from providers and other external sources.

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 recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to, non-physician 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 recredentialing activities for CCN are performed at CalOptima and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and recredentialing of Ops, ~~such as~~including, 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 Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing 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 recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate ~~primary care provider (~~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~~APL 20-006. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for 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.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey ~~physical accessibility review survey~~ (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 20-006 and CalOptima policies. ~~The~~ An Initial Medical Record Review shall be completed within 90 calendar days ~~of~~ from the date that members are first assigned to the provider. An additional extension of 90 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. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when ~~determined~~ deemed necessary based on monitoring, evaluation or corrective action plan (CAP) follow-up issues.

Physical Accessibility Review Survey for Seniors and Persons ~~with~~ 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

The medical record provides legal proof that the member received care. CalOptima requires that ~~its~~ contracted delegated HNs make certain that each member's medical record is maintained in an accurate, ~~manner that is~~ current, detailed, organized and easily accessible ~~to treating practitioners~~manner. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. 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 provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and 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~~ to Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant 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~~ using continuous improvement tools (i.e., quality improvement plans or ~~Plan-Do-Study-Act~~PDSA) 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 when the monitoring and evaluation results may indicate ~~a problem, which can be~~problems that can be corrected by changing policy or procedure.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the ~~QI and PHM~~QI and PHM teams 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~~ processes and programs to:

- Report, monitor and trend outcomes
- 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 performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QI Program, ~~such as~~including, but not limited to, network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize ~~health networks~~HNs and providers to meet quality performance targets and deliver ~~high quality of~~quality care

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

- Claims information/activity
- Encounter data
- Utilization data
- Case management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings ~~(Stars) and Health Outcomes Survey (HOS) scores~~ data
- Population Needs Assessment
- ~~Results of risk stratification~~
- HEDIS performance
- Member and provider satisfaction surveys

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores~~, Stars and HOS measures~~

and CMS Star Ratings. This information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

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 health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

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

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

CalOptima developed a comprehensive PHM Strategy ~~for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, which~~that includ~~es~~ing a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to ~~our~~ members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner ~~across the entire health care continuum and life span~~.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members. ~~such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.~~ Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care ~~Health~~ Plans) will aid the PHM ~~strategy~~ Strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs and CCIPs. Quality Initiatives for ~~2021~~2022 are tracked in the QI Work Plan and reported to the QIC.

In 202~~1~~2, the PHM Strategy will ~~be~~ include greater focus~~focused~~ on addressing health inequities and ~~social determinants of health for members~~SDOH. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand ~~existing member~~ outreach ~~efforts~~ and~~or~~ initiate new initiatives focused on SDOH and health equity as follows:

- Back-to-school immunization clinics for school-aged children (Tdap, COVID-19 vaccine, etc.)
- COVID-19 Member Health Rewards for CalOptima m~~M~~embers, ~~Experiencing Homelessness~~with special focus on those experiencing homelessness
- Improving COVID-19 v~~V~~accine ~~A~~access for ~~H~~homebound ~~M~~members and other ~~H~~high-~~R~~risk populations
- Mobile ~~D~~diaper ~~B~~banks for ~~F~~families of ~~I~~infants and ~~A~~adolescent ~~M~~members in ~~C~~collaboration with Women, Infants & Children (WIC) and the Community Action Partnership
- Improving access for ~~E~~eligible CalOptima ~~M~~members to CalFresh benefits ~~with Social Services Agency~~
- Improving ~~A~~access to ~~Mmammography (mobile mammography)~~breast ~~C~~cancer ~~S~~screenings for Korean and Chinese members via mobile mammography
- ~~Fresh Produce Delivery for Members with Poorly Controlled Diabetes – CalOptima Community Network Specific~~
- Remote ~~M~~monitoring for ~~M~~members with ~~C~~chronic ~~C~~conditions
- Escape The Vape (Great American Smoke Out) ~~A~~annual event that offers vape and tobacco prevention to school--aged children
- Shape Your Life Childhood Obesity Program, ~~improving~~with group classes to improve ~~education~~ awareness of~~for~~ good nutrition and physical fitness for adolescents ~~through group classes~~
- Member Health Needs Assessment

~~expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.~~

~~Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing comorbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member-focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.~~

The PHM team also focuses on improvement projects, such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for ~~our~~ members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines

- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, 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 remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both ~~significant~~ demonstrated 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~~pursue 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
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agencywide PHM 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. They and are designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include exercise, Nutritionnutrition, Hyperlipidemiahyperlipidemia, Hypertensionhypertension, Perinatal perinatal Healthhealth, Shape Shape Your Life/Weight weight Managementmanagement, Tobacco tobacco Cessationcessation, Asthmaasthma, Immunizationsimmunizations and Well well-Child child Visitsvisits.

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 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 With Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach is utilized that entails the formation of a partnership between the patientmember, the health care practitioner and CalOptima. The 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 supports the CA OSGCalifornia Surgeon General and Proposition 56 requirements for ACE Adverse Childhood Event (ACE) screening, as well as identification of social determinates of health (SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the PHM program for all 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, including Health Risk Assessment (HRA) or Health Needs Assessment (HNA) ~~data~~for ~~model of care~~MOC members. ~~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 evidence-based guidelines distributed to ~~members and practitioners~~ providers who~~that~~ are relevant to chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD).

- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources.

- Development of individualized care plans that include input from the member, care giver, ~~primary care provider~~PCP, specialists, social worker~~,~~ and providers involved in care management, as necessary.

- Coordination of services for members for appropriate levels of care and resources.

- Documentation of all findings.

- Monitoring, reassessing~~,~~ and modifying the plan of care to drive appropriate service quality, timeliness~~,~~ and effectiveness ~~of services~~.

- Ongoing assessment of outcomes.

CalOptima's ~~e~~Case ~~m~~Management program includes three care management levels ~~(CML)~~ that reflect the acuity of ~~care management~~ needs: ~~C~~complex case management, care coordination~~,~~ and basic case management. ~~-~~Members within defined ~~models of care~~MOCs ~~—:~~ ~~-~~SPD, WCM, OCC and OC ~~—~~ are risk~~-~~stratified ~~on~~upon enrollment~~ligibility~~ using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool ~~utilizes~~uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic

conditions, and pharmacy.~~This stratification results in the categorizing of members as "high" or "low" risk and informs outreach for the initial risk assessment.~~

~~Health Risk Assessment (~~HRA~~)~~ and ~~Health Needs Assessment (~~HNA~~)~~

The comprehensive risk assessment facilitates care planning and offers actionable items for the ~~Interdisciplinary Care Team (~~ICT~~)~~. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. -The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. -Risk assessments are completed with the initial visit ~~eligibility~~ and then on an annual basis. ~~Oversight RN Review~~

~~CalOptima's delegated model reflects 100% RRN review of collected risk assessments (HRA/HNA) and CML assignment. The data is analyzed and sent to the delegated networks who develop the ICT and Individualized Care Plan (ICP). The delegated networks return the completed ICP/ICT and there is 100% RN review to ensure risk assessment needs are addressed and model of care requirements are met.~~

~~Interdisciplinary Care Team~~**ICT**

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~~depending on the results of the member's HRA and/or evaluation or changes ~~in the member's~~in 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~~ the member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), ~~case management team~~case manager, behavioral health specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT ~~teams are de~~is designed to ~~see~~ ensure that members' needs are identified and managed by an appropriately composed team.

The ~~Interdisciplinary Care Teams~~ICT ~~process~~ levels are~~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~~Individual Care Plan (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 at CalOptima for CCN ~~Members~~members.
  - Team Composition ~~(appropriate to identified needs)~~: member, caregiver or authorized representative, HN ~~Medical~~ medical ~~Director~~director, PCP and/or specialist,

ambulatory case manager ~~(CM)~~, hospitalist, hospital ~~CM~~ case manager 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
  - Care coordination or complex case management
  - Case management of high-risk members
  - Coordination of ICPs for high-risk members
  - Facilitating communication among member, PCP, ~~and~~ specialists and vendors ~~communication~~
  - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition
  -

~~Individualized Care Plan (~~ICP

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals ~~including~~and target dates. ~~–~~Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per ~~CML~~case management level. The ICP is updated annually and with change in condition.~~with key events such as hospitalization and transitions of care.~~

~~Models of Care~~**MOCs:**

Dual Eligible Special Needs Plan (D-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 members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the ~~patient's~~ member'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~~for a subset of ~~patients~~ members 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~~ members who may be at risk of rehospitalization.

- High-risk and high-utilization program ~~aimed a~~for~~t~~ ~~patients~~ members who frequently use emergency department ~~(ED)~~ services~~,~~ or ~~or~~ have frequent hospitalizations,~~,~~ and at-high-risk individuals.

- Hospital case management program ~~designed~~ to coordinate care for ~~patients~~ members during an inpatient admission and discharge planning.

Care management program focuses on ~~patient~~member-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.

Seniors and Persons with Disability (SPD)

The goal of case management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. -The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole Child Model (WCM)

The goal of case management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima coordinates the ~~beneficiary's~~ full scope of health care needs inclusive of ~~primary~~ preventive care, specialty health, mental health, education and training. ~~The goal of~~ WCM ~~is to~~ ensures that each CCS-eligible member receives case management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this ~~will be dependent~~depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs~~contributes to~~ the ICT and ICP development.

~~California Advancing and Innovating Medi-Cal for All (~~CalAIM~~im~~IM's~~) and~~ Enhanced Care Management (ECM)

~~Implementation of ECM is scheduled for~~began~~Effective~~ January 1, 2022, ~~.~~–ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of m~~M~~embers with the most complex medical and social needs. –These members are ~~expected to be~~ among the most vulnerable and highest-need Medi-Cal m~~M~~anaged ceare ~~M~~members. -ECM ~~will~~ reflects a systematic coordination of services and comprehensive care management that is community-~~-~~based, interdisciplinary, high-~~-~~touch and person-centered. The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social ~~needs,~~ and long-term ~~services and supports~~needs for members.~~, including participating in the care planning process, regardless of setting. The model uses HNA, ….(what to say here as it is different?)~~ Eligible members may participate in ECM and/or Community Supports through ~~the~~ CalAIM ~~program~~.

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~~ The 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~~ people 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 who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review and authorization of BHT services.

CalOptima offers ~~Alcohol Misuse Screening and Counseling (AMSC)~~ Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the ~~primary care physician (~~PCP setting to members ~~eleven (~~11 ~~)8~~ years and older, including pregnant women. ~~who may misuse alcohol. Providers in primary care settings screen for~~ When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol ~~misuse~~ or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD) ~~and provide 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 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~~moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

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

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

CalOptima is participating in two of DHCS' incentive programs focused on improving behavioral health care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and behavioral health outcomes, care delivery efficiency and ~~patient~~ member experience. CalOptima is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12~~twelve~~ projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of ~~the Administration administration and State state Legislature legislature~~a state effort to prioritize behavioral health services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county behavioral health and CalOptima by developing infrastructure to improve access and increase the number of transitional kindergarten ~~(TK)~~ through 12th~~th~~-grade students receiving ~~preventative,~~ early interventions and preventive ~~and behavioral health~~BH services.

OC and OCC

In 2022, OC ~~/~~and OCC behavioral health continues to be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers ~~Alcohol Misuse Screening and Counseling (AMSC)~~ Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD). ~~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 refer 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, member eligibility at the time of service and subject to medical necessity. Contracts specify that medically necessary services are those that 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~~member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ~~promotes~~~~promote efforts to~~ ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2022~~0~~ UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve 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 ~~2021~~2022 UM Program Description.

~~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 road map 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 road map. 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 express 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~~ members 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 member-specific 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
- 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~~ consider the member's language 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~~brochures that 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), which ~~allows the opportunity for the practitioner to~~ helps 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~~ Using ~~facility site review~~FSRs, Physical Accessibility Review Survey (PARS) and medical record review results from ~~practitioner~~ providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate~~ing~~ ADA and SPD site reviews ~~audits~~ into the general ~~facility site review~~FSR 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 postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of flu and pneumonia vaccines
  - COVID-19 infection ~~Prevention~~ prevention and ~~Protective~~ protective ~~Equipment~~equipment
  - MRSA prevention program – Shared Healthcare Intervention to Eliminate Life-Threatening Dissemination of Multi-drug Resistant Organisms (~~Shield~~SHIELD)

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima strongly believes in the importance of providing culturally and linguistically appropriate services to ~~its~~ members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. ~~Such s~~Services include, but are not limited to, ~~Face-to-Face Interpreter~~face-to-face interpreter services, including American Sign Language, at key points of contact~~,~~; 24-hour access to telephonic interpreter services~~,~~; and member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print or audio.

~~Since CalOptima serves a large and culturally diverse population, t~~The seven most common languages spoken for all CalOptima programs are: English, 59~~8~~6 ~~percent,~~ %; Spanish, ~~28~~ 26 ~~percent~~%~~,~~; Vietnamese, ~~11~~10 ~~percent~~%~~,~~; Farsi, 1 ~~percent~~%~~,~~; Korean, 1 ~~percent~~%~~,~~; Chinese, ~~<~~less than 1 ~~percent~~%; and Arabic, less than ~~<~~1 ~~percent~~% ~~and all others at 3 percent, combined~~. CalOptima provides member materials as follows:

- Medi-Cal member materials are ~~provided~~ in seven languages: English, Spanish, Vietnamese, ~~Korean,~~ Farsi, Korean, 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, Farsi, 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~~ our 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 a~~Advisory ~~c~~Committees~~s~~MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas
- Improve cultural competency in materials and communications
- Improve network adequacy to meet the needs of underserved groups
- Improve other areas of need~~s the organization deems~~as appropriate~~.~~

~~The approach for~~Serving a culturally and linguistically diverse membership include~~s~~:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- 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 member-focused interventions with culturally competent outreach materials that focus on race~~/~~-, ethnic~~ity /~~-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- 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 delegated HNs that are required to meet all contractual, statutory and ~~and~~ regulatory requirements, as well as 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's ~~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~~ Program for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Behavioral Health for ~~MC~~Medi-Cal, OC and OCC ~~lines of business~~
- 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, and peer review process on specific, referred cases
- Potential Quality Issue investigations
- Development of systemwide 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 recredentialing standards for both practitioners and ~~organizational providers (~~OPs
- Credentialing and recredentialing of OPs
- 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 ~~2021~~2022 Delegation Grid.

See Appendix B — ~~2021~~2022 Delegation Grid

In Summary

As stated previously, CalOptima~~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 APPENDIX A — 2021 QI Work Plan~~

Appendix A — 2022 QI Work Plan

Appendix B — ~~2021~~2022 Delegation Grid

~~**Appendix C — Organizational Chart**~~

I. PROGRAM OVERSIGHT

A. 2022 QI Annual Oversight of Program and Work Plan
B. 2021 QI Program Evaluation
C. 2022 UM Program
D. 2021 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, OC P4V, Data Mining/Bridge efforts)
M. Improvement Projects (All LOB)PIPs
N. Improvement Projects (All LOB)QIPs
O. Improvement Projects (All LOB)CCIP's
P. PPME/QIPE: HRA's
Q. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
R. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
S. CalAIM
T. Health Equity
U. DHCS Comprehensive Quality Strategy
V. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:

Submitted and approved by QAC: Date:

Quality Improvement Committee Chairperson:

Richard Pitts, D.O., Ph.D Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date:

B. 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.

C. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)

D. Follow-Up After Emergency Department Visit for Mental Illness (FUM)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)

B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

C. Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot

V. QUALITY OF CLINICAL CARE- Maternal Child Health

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

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA

B. Blood Lead Screening (BLS) (LSC)

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Expanding Network of Providers Accepting New Patients
C. Improve Access: Timely Access (Appointment Availability)
D. Improve Access: Telephone Access
E. Improving Access: Subcontracted Network Certification

VIII. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.
B. Post-Acute Infection Prevention Quality Incentive (PIPQI)
C. Orange County COVID Nursing Home Prevention Program.

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT									
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	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 by April 2022	Marsha Choo		X			
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo		X			
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Mike Shook		X			
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Mike Shook		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Marie Jeannis/Kelly Giardina		X			
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Marsha Choo/Laura Guest		X			
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Tyronda Moses		X			
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo		X			
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook		X			
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD		X			
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Sandeep Mital		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, **OC P4V**, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures. **[NEW] Development of the OC P4V program for MY2023**	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital		X			
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs **MC PIPs:** 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	Health Equity	X			
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs **MC QIP:** 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD) b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	Health Equity	X			
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on **All LOB CCIPs** 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn		X			
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals **OC and OCC** PPME and QIPEs 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Sloane Petrillo/S. Hickman		X			
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 addition of virtual outreach visits to shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Katie Balderas/Sloane Petrillo	SDOH	X			
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Sloane Petrillo/Natalie Zavala	SDOH	X			
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Katie Balderas/Marie Jeannis	Health Equity	x			
DHCS Comprehensive Quality Strategy	**Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.**	**[NEW} to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy**	**12/31/2022**	**Marie Jeannis/Marsha Choo**	Health Equity				
Student Behavioral Health Incentive Program (SBHIP)	**Achieve program implementation period deliverables**	**[NEW} to 2022 QI Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.**	**12/31/2022**	**Natalie Zavala**	**Health Equity**				
II. QUALITY OF CLINICAL CARE- Adult Wellness									
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	Health Equity	X			
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health									
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2021 Goal:** FUH 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:34.67%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala		X			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS MY2021 Goal:** MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala		X			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	**HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)**	**[NEW} to 2022 QI Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.**	**12/31/2022**	**Natalie Zavala**					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	**HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)**	**[NEW] to 2022 QI Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.**	**12/31/2022**	**Natalie Zavala**					
IV. QUALITY OF CLINICAL CARE- Chronic Conditions									
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2021** HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn		X			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	**1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx.**	**There are four parts to this multidispclinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.**	12/31/2024	**Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson**		X			
V. QUALITY OF CLINICAL CARE- Maternal Child Health									
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	Health Equity	X			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness									
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2021** Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	Health Equity	X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2021 Goal (3 Year Goal)**: Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn		X			
VII. QUALITY OF SERVICE- Access									
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Michelle Laughlin/Jennifer Bamberg/Maggie Hart		X			
Improve Access: Expanding Network of Providers Accepting New Patients	**Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%**	**[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.**	**12/31/2022**	**Marsha Choo/Jennifer Bamberg**					
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards 3) See Virtual Care Strategies	12/31/2022	Marsha Choo/Jennifer Bamberg		X			
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After 3 Attempts** from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg		X			
Improving Access: Subcontracted Network Certification	**Certifiy all HNs for network adequacy**	**[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.**	**7/31/2022**	**Marsha Choo/Jennifer Bamberg**					

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VIII. SAFETY OF CLINICAL CARE									
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	**HEDIS MY2021** Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving inctreased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regardign the importance of having a post dischage visit with the members PCP.	12/31/2022	Mike Shook		X			
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) To reduce the number of nosocomial infections for LTC members. 2) To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses will be visiting each facilitiy/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofor (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	12/31/2022	Michelle Findlater/Scott Robinson		X			
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities; toolkit, consultative services and webinars provided to all Orange County nursing homes free of charge	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2022. Planned activities include: 1) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 2) Provide guidance, protocols for preventing spread of COVID 3) Support training on how to stock and use protective gear 4) Develop high compliance processes for protection of staff and residents. 5) Make toolkit available for free at www.ucihealth.org/stopcovid 6) Provide COVID prevention helpline to offer guidance and information to nursing home staff 7) Conduct point prevalence sweeps of residents for multi-drug organisms	5/31/2022	Cathy Osborn/**Scott Robinson**		X			

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
New	**QI1E: Promoting Organizational Diversity, Equity and Inclusion**	**X**		**X**	**[NEW] Effective 7/1/2022, 2022 HP Standards**
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	
2.2.4	PHM2D: Segmentation-PHM	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X	X	X	
3.4.2	NET4B: Continued Access to Practitioners	X	X	X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA (Interim Surveys only)
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				For Medi-Cal or OC/OCC this function or activity is not Applicable
4.9.6	UM9F: Appeals Overturned by the IRO				For Medi-Cal or OC/OCC this function or activity is not Applicable
4.9.7	Provider Level 1 UM Appeals	X	X	X	
4.9.8	Provider Level 2 UM Appeals	X			
4.10.1	UM10A: Written Process	X			For Medi-Cal, this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
4.10.2	UM10B: Description of the evaluation Process	X			For Medi-Cal, this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
~~4.11.1~~	~~UM11A: Pharmaceutical Management Procedures (Policies and Procedures)~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.2~~	~~UM11B: Pharmaceutical Restrictions/Preferences~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
~~4.11.3~~	~~UM11C: Pharmaceutical Patient Safety Issues~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.4~~	~~UM11D: Reviewing and Updating Procedures~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.5~~	~~UM11E: Considering Exceptions~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
4.12.1	UM12A: UM Denial System Controls	X	X	X	
New	**UM12B: UM Denials System Controls Oversight**	**X**	**X**	**X**	**[NEW] Effective 7/1/2022, 2022 HP Standards**
4.12.2	UM12C: UM Appeal System Controls	X		X	
New	**UM12D: UM Appeals System Controls Oversight**	**X**		**X**	**[NEW] Effective 7/1/2022, 2022 HP Standards**
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
4.14.1	Second Opinion	X	X	X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	
New	**CR1D: Credentialing System Controls Oversight**	**X**	**X**	**X**	**[NEW] Effective 7/1/2022, 2022 HP Standards**
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				For Medi-Cal, this standard is not applicalbe because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activities is retained by CalOptima and is not delegated to the Delegate.
5.7.4	CR7D: Assessing Medical Providers	X	X	X	
5.7.5	CR7E: Assessing Behavioral Healthcare Providers	X			For Medi-Cal, this standard is not applicable because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activities is retained by CalOptima and is not delegated to the Delegate.
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations	X			For Medi-Cal , this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.3.2	ME3B: Communication with Prospective Members	X			For Medi-Cal , this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.3.3	ME3C: Assessing Member Understanding	X			For Medi-Cal , this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.4.1	ME4A: Functionality: Website	X			Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X			Not Required for Renewal Survey
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Timeliness of Claims Processing	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR) related to Claims Payment Decisions- Level 1	X	X	X	
7.1.7	Provider Dispute Resolution related to Claims Payment Decisions- Level 2	X			
7.1.8	Third Party Liability (TPL)	X	X	X	
8.1.1	Provider Complaint Processing	X			

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
9.1.1	MED1H: Notification of Termination of a Practitioner or Practice Group	X		X	
9.2.1	MED2A: Adoption of Practice Guidelines	X		X	
9.2.2	MED2B: Distributions of Practice Guidelines	X		X	
9.3.1	MED3B: Site Visits and Ongoing Monitoring	X		X	
9.4.1	MED5A: Coordination Health Care Services for Members	X	X	X	
9.4.2	MED5B: Maintaining and Sharing Member Health Records	X		X	
9.5.1	MED8D: Informing Members About the QI Program	X		X	
9.6.1	MED9D: Affirmative Statement about Incentives	X		X	
9.7.1	MED12D: Providing Information to Medicaid Members in the Practitioner Directory	X		X	
9.7.2	MED12F: Providing Information to Medicaid Members in Denial Notifications	X		X	
9.7.3	MED12G: Providing Information to Members in Appeal and Grievance Notifications	X		X	
9.7.4	MED12H: Interpreter Services for Medicaid Members	X		X	

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2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
9.7.5	MED12I: Usability Testing of Member Materials	X		X	
9.8.1	MED13B: Offering Special Communication Assistance	X		X	
9.9.1	MED14A: Directory Data	X		X	
9.9.2	MED14B: Pharmacy Directory Data	X		X	
9.9.3	MED14C: Behavorial Healthcare Directory Data	X		X	
9.9.4	MED14D: Long-Term Services and Supports Provider Directory Data	X		X	
9.10.1	MED15A: Delegation Agreement	X			May not be Delegated
9.10.2	MED15B: Provisions for PHI	X			May not be Delegated
9.10.3	MED15C: Predelegation Evaluation	X			May not be Delegated
9.10.4	MED15D: Review of Delegates MED Activities	X			May not be Delegated
9.10.5	MED15E: Opportunities for Improvement	X			May not be Delegated
Note: NCQA Delegated Elements are based on 2021 HP Standards. QI1E, UM12B,UM12D, CR1D are new to 2022 HP Standards (will be added new Delegation Agreements in 2022)					

CalOptima
A Public Agency
Better. Together.

2022

QUALITY IMPROVEMENT PROGRAM

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2022 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard Pitts, D.O., Ph.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

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

Board of Directors Chair:

Supervisor Andrew Do **Date**

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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 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. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.

- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

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

Stewardship

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

We are "Better. Together."

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

Our Strategic Plan

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

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

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

As both, CalOptima must:

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

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. CalOptima marked 25 years of service to Orange County's Medi-Cal population in 2020.

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, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

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

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

Members With Special Health Care Needs

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

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

OneCare provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality 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 individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

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

Scope of Services

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

OneCare Connect

The 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 both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated

services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits and an out-of-the-country urgent/emergency care 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.

OneCare Connect 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 individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

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

The Cal MediConnect demonstration program is ending in 2022, and CalOptima is planning to transition OCC members to OC, effective January 1, 2023.

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 care, preventive care and behavioral health services covered under Medi-Cal and Medicare. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits and over-the-counter benefits. OCC also includes personalized services through the PCCs to ensure each member receives the services they need when they need them.

PROGRAM INITIATIVES

Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a public health emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2022 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity have existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths, but make up only 6% of the

population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as part of the QI Work Plan.

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

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

Quality Strategy Goals

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

Quality Strategy Guiding Principles

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

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

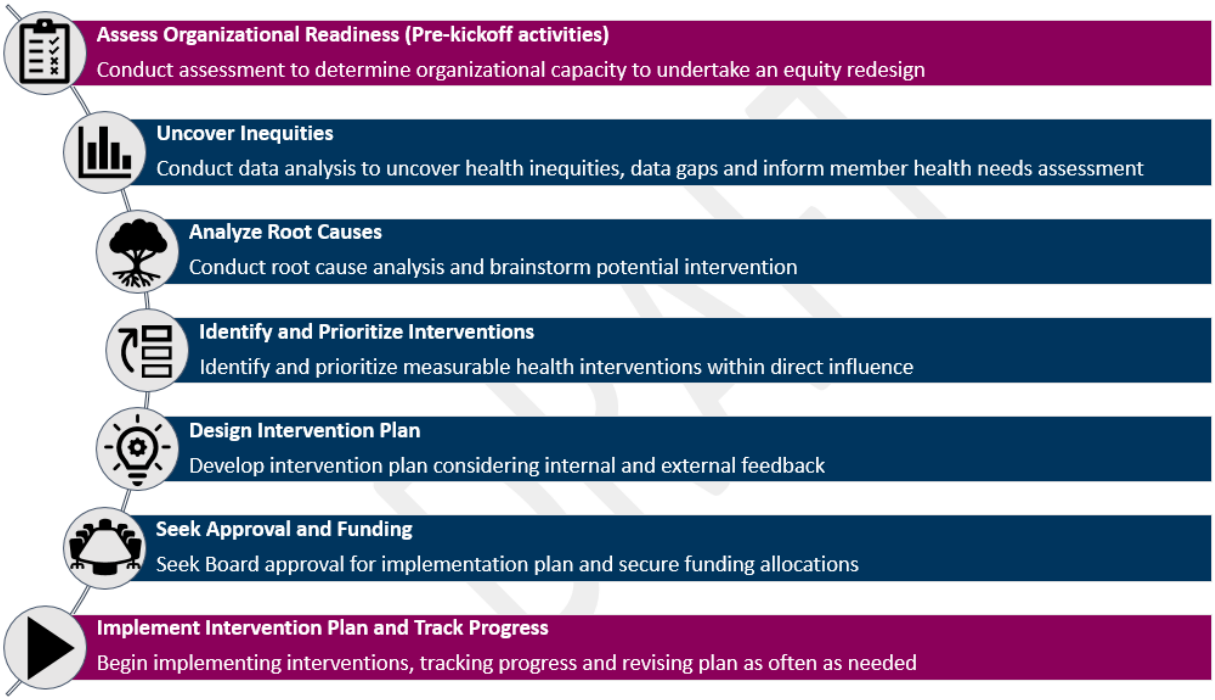
Health Equity Framework

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

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

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

from internal and external stakeholders and include their input in the intervention and design process.



California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms.

CalAIM has three primary goals:

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

Enhanced Care Management and Community Supports

Beginning on January 1, 2022, CalOptima implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services that addresses the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits and discharge delays.

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

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

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

- Members experiencing homelessness (adults and children)
- High utilizer adults
- Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)

Additionally, members participating in WPC and/or HHP automatically transitioned into ECM.

HHP and WPC service providers will continue to provide services under Community Supports as CalOptima works to expand the network of Community Supports providers that have the expertise and capacity to provide the specific types of services. Members eligible for Community Services must consent to participate and receive services. Community Support services include the following:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Medically tailored meals/medically supportive foods
13. Sobering centers
14. Asthma remediation

Beginning January 1, 2022, CalOptima offers the following four Community Supports services:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Recuperative care (medical respite)

CalOptima will continue to assess the needs the of members and collaborate with community stakeholders to add new Community Supports.

2021–22 CalOptima Community Network (CCN) Pilot Program

Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members With Poorly Controlled Diabetics

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

1. Pharmacist Involvement and Intervention:
   CalOptima pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptima believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with primary care providers (PCPs) and health coaches/registered dietitians/case managers.
2. Health Coach/Registered Dietitian Management Intervention:
   CalOptima health coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials and referral to other community resources based on needs. Health coaches/registered dietitians will also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.
3. Non-Monetary Member Incentives:
   CalOptima would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.
4. Provider Incentives:
   In order to have successful provider support, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary diabetes program. Providers are eligible for incentives when they manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for Medi-Cal only and does not affect OC, OCC or PACE.

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have options for participating in CalOptima's programs to provide health care to CalOptima members. Providers can contract through CalOptima Direct, CalOptima Direct-Administrative and/or CalOptima Community Network (CCN) and/or contract with a CalOptima HN. CalOptima members can choose CCN or one of 12 HNs representing more than 9,400 practitioners.

CalOptima Direct (COD)

CalOptima Direct has two elements: CalOptima Direct-Administrative and CCN.

- 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 OC or OCC), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

- CalOptima Community Network (CCN)

  CCN doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks

CalOptima has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

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

Through our delegated HNs, CalOptima members have access to more than 1,500 PCPs, more than 7,900 specialists, 40 acute and rehabilitative hospitals, 31 community health centers and nearly 100 long-term care facilities.

CalOptima contracts with the following HNs:

Health Network	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI Care Health Network	PHC	-	PHC
AMVI/Prospect Medical Group	-	SRG	-
CHOC Health Alliance	PHC	-	-
Family Choice Medical Group	PHC	SRG	SRG
HPN-Regal Medical Group	HMO	-	HMO
Kaiser Permanente	HMO	-	-
Noble Mid-Orange County	SRG	SRG	SRG
Optum Care Network - Arta	SRG	SRG	SRG
Optum Care Network - Monarch	HMO	SRG	HMO
Optum Care Network - Talbert	SRG	SRG	SRG
Prospect Medical Group	HMO	-	HMO
United Care Medical Group	SRG	SRG	SRG
Delegate	**Medi-Cal**	**OneCare**	**OneCare Connect**
Vision Service Plan	VS	VS	VS

HMO=Health Maintenance Organization
PHC=Physician-Hospital Consortium
SRG=Shared Risk Group
VS=Vision Service

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

- Utilization management
- Basic and complex case management
- Claims
- Contracting
- Credentialing of practitioners
- Customer service

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MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2022

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

Membership Data from December 31, 2021, Financial Information

Total CalOptima Membership
870,489

Program	Members
Medi-Cal*	852,805
OneCare Connect	14,933
OneCare (HMO SNP)	2,330
Program of All-Inclusive Care for the Elderly (PACE)	421

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

Member Age (All Programs)

9%	0 to 5
27%	6 to 18
33%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

59%	English
26%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

41%	Temporary Assistance for Needy Families
35%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
5%	People with Disabilities
<1%	Long-Term Care
<1%	Other

Financial Information FY 2021–22 Budget

Program	Annual Budgeted Revenue	% Total Budgeted Revenue
Medi-Cal	$3,249,878,660	88.89%
OneCare Connect	$339,332,450	9.28%
OneCare	$25,409,771	0.69%
PACE	$40,274,039	1.10%
MSSP**	$1,218,536	0.03%

Note: Fiscal Year 2021–22 Operating Budget began on July 1, 2021.
** Multipurpose Senior Services Program (MSSP)

Total Budgeted Annual Revenue
$3.7 billion

CalOptima spends nearly 96 cents of every dollar on member care.

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QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service 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 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 primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging 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 or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

CalOptima is committed to promoting diversity in practices throughout the organization, including HR best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

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 HNs. Through the QI Program — and in collaboration with providers and community partners — CalOptima strives to continuously

improve the structure, processes and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the 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 care and experiences.

- Maintain agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

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

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management and support processes.

- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.

- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring certain contracted facilities report to the public health authority (HCA) outbreaks of conditions and/or diseases, which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.

- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers (OPs) to assure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Audit & Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD network providers serving CalOptima's various populations:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- Timely identify 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
- Ensure 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
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances
- Ensure the reliability of risk prevention and risk management processes
- Ensure compliance with regulatory agencies and accreditation standards
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans
- Promote the effectiveness and efficiency of internal operations
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values
- Ensure 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 described 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 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 approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, 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 conduct annual evaluation, provide strategic direction and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim (which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) has 15 voting members, with each seat representing 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 preventive services. The MAC meets on a monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medical safety net
- County of Orange Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by 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. The OCC MAC has 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the program.

The OCC MAC membership includes 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
- In-Home Supportive Services (IHSS) provider or union representative
- LTC facility representative

- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA Behavioral Health
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - 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 bimonthly meetings are open to the public.

Provider Advisory Committee

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

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

- Family representatives (seven 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 current recipients of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services

- Interests of children representatives (four seats)
    - Community-based organizations; or
    - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC meets bimonthly, and 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 Information Officer (CIO) provides oversight of CalOptima's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the agency's risk exposure.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Program Implementation, Process Excellence, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, and Coding Initiatives.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI Program 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.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO collaborates with directors and medical directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Case Management, Population Health Management, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. COS is responsible for achieving operational efficiencies to support CalOptima's strategic plan, goals and objectives.

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the physician designee who chairs the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care physician in the QI Program who serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC) and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Executive Director, Quality & Population Health Management (ED Q&PHM) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED Q&PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED Q&PHM are the directors of Quality Analytics, Quality Improvement and Population Health Management.

Executive Director, Behavioral Health Integration (ED BH) is responsible for oversight of CalOptima's Behavioral Health (BH) program including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Clinical Operations (ED 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 CO serves as a member of the executive team and, with the CMO, DCMO and ED Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED PI is the director of Process Excellence.

Executive Director, Public Affairs (ED PA) is responsible for CalOptima's Communications, Government Affairs, Community Relations and Strategic Development departments. ED PA is charged with assisting the CEO in carrying out organizational goals, including overseeing the development of the CalOptima Strategic Plan and implementation of communications strategies to highlight CalOptima programs and priorities. Under ED PA's leadership, the Public Affairs team members collaborate on efforts that support the CalOptima mission and reach internal and external audiences, ranging from employees and members to government officials and the media. Reporting to ED PA are the directors of both Communications and Strategic Development.

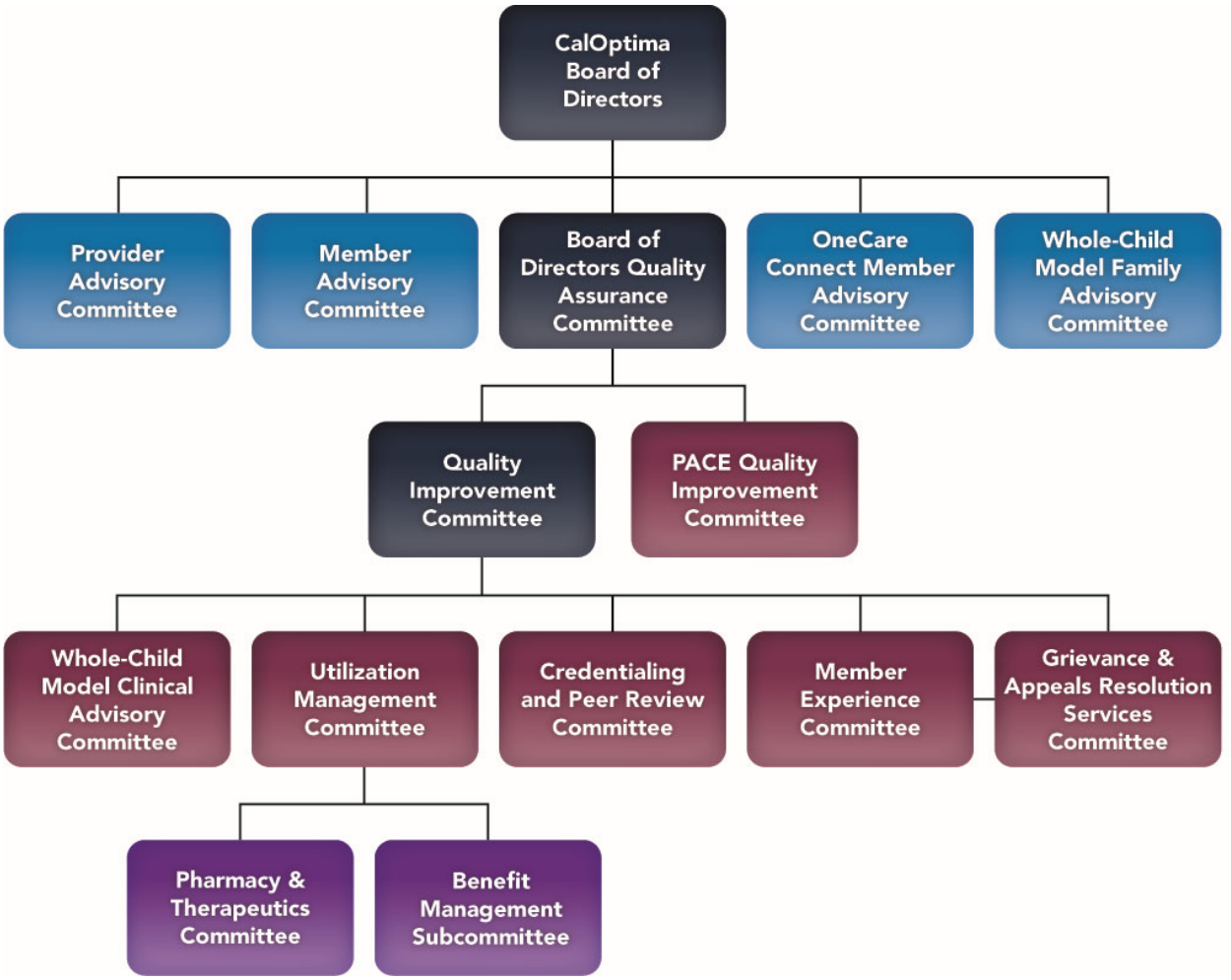
Executive Director, Compliance (ED C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in

collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The ED C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED C 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 NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED 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 and quality health care services is maintained throughout the service delivery network.

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

Committee Organization Structure — Diagram



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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 delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to CalOptima, including a 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, 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:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives
- Overseeing the analysis and evaluation of QI activities
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI Program activities
- Identifying and prioritizing needed actions and interventions to improve quality
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions

Practice patterns of providers, practitioners and delegated HNs are evaluated, such as UM over/under utilization in collaboration with applied behavioral analysis utilization. Recommendations are made to promote practices that all members receive medical and behavioral health 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, and delegated HNs.

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

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data 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:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima Chief Medical Officer (Chair or Designee)
- CalOptima Medical Directors
- CalOptima Behavioral Health Integration Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four 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 QIC 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 QIC Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- 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 produced only for committee approval.

Credentialing and 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 who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or physician 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.

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 medical, behavioral health and LTSS services for CCN and through the delegated HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity 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. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. 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 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. It reviews anticipated and actual drug utilization trends, parameters and results based on 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 decisions 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 benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance 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.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima WCM program. The WCM

CAC works in collaboration with county CCS, the WCM FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee 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's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction. The MEMX committee 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; review customer service metrics; and evaluate complaints, grievances, appeals, authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2022, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2022 and MY 2023 CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of 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 Committee are defined in its charter.

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 delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance

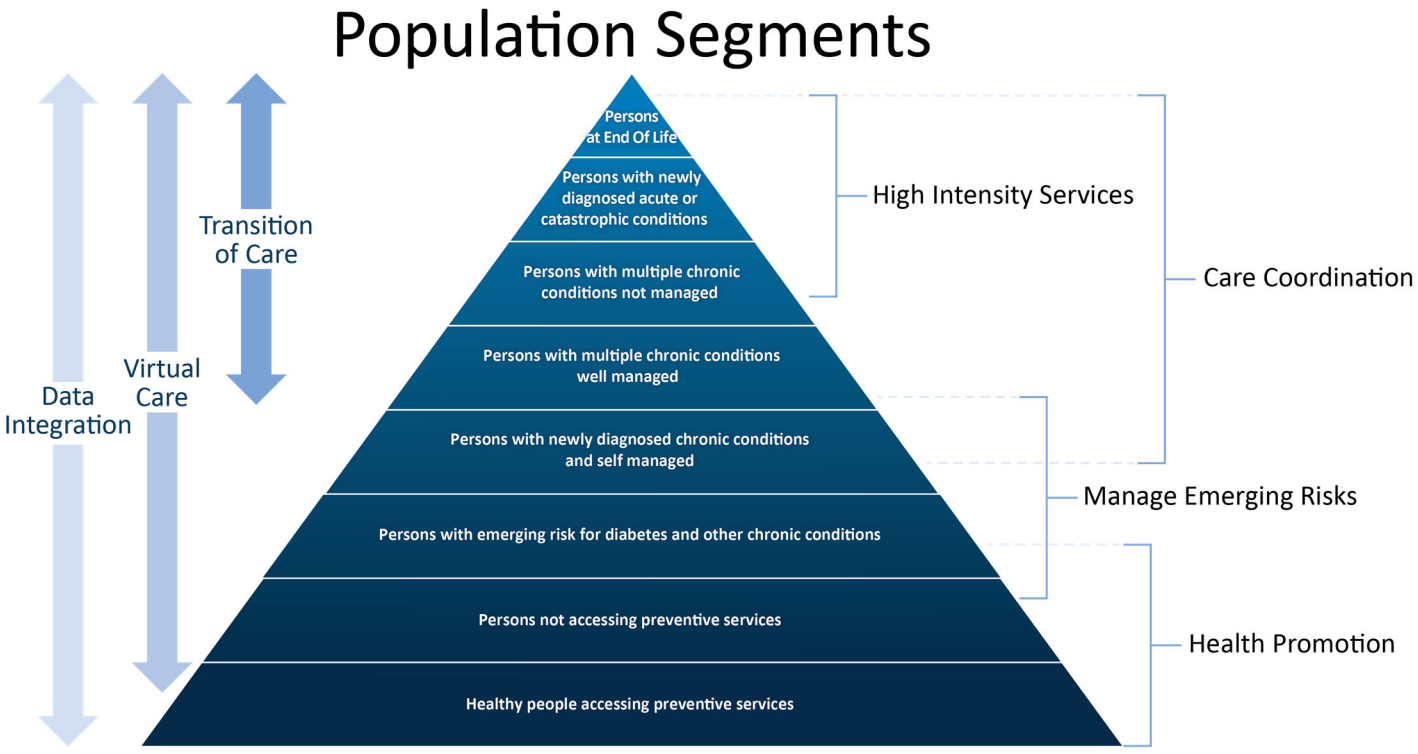
with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

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 and structure provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by stratifying the 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 (MOC), the 2022 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.



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CalOptima's 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 effective in managing the health care needs of 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.

2022 QI Goals and Objectives

CalOptima's QI Goals and Objectives are aligned with CalOptima's 2022–23 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
2) Ensure member's safety during COVID-19 pandemic by aiming for 80% COVID-19 vaccine rate or community immunity
3) Improve quality of care and member experience by maintaining NCQA Health Plan Rating of 4.0, and at least a Three-Star Rating for Medicare.
4) Engage providers through the provision of new Pay for Value (P4V) program for Medi-Cal and the new OneCare programs through incentivize measures related to our STAR rating

These top four priority goals were chosen to be aligned with CalOptima's strategic objectives, the pandemic, as well as continued goals related to access to care and NCQA accreditation. The 2022 QI Workplan details the planned activities to meet the COVID-19 vaccine aim, which include strategies for immunization, targeted communication and a member incentive. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for OC and OCC. 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
- Assuring proper identification of SDOH
- 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 the 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. A QI Work Plan addendum 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 CalOptima strategic priorities and the most recent and trended HEDIS, 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
- 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 CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the 2022 QI Work Plan.

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 — 2022 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 issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience 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, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for Seniors and Persons with Disabilities (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 occurs at all levels of the organization.

- Individuals and administrators initiate improvement projects within their area of authority that 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 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.

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%–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 tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depending on the type of opportunity for improvement identified. The PDSA model is the overall framework for continuous process improvement. This includes:

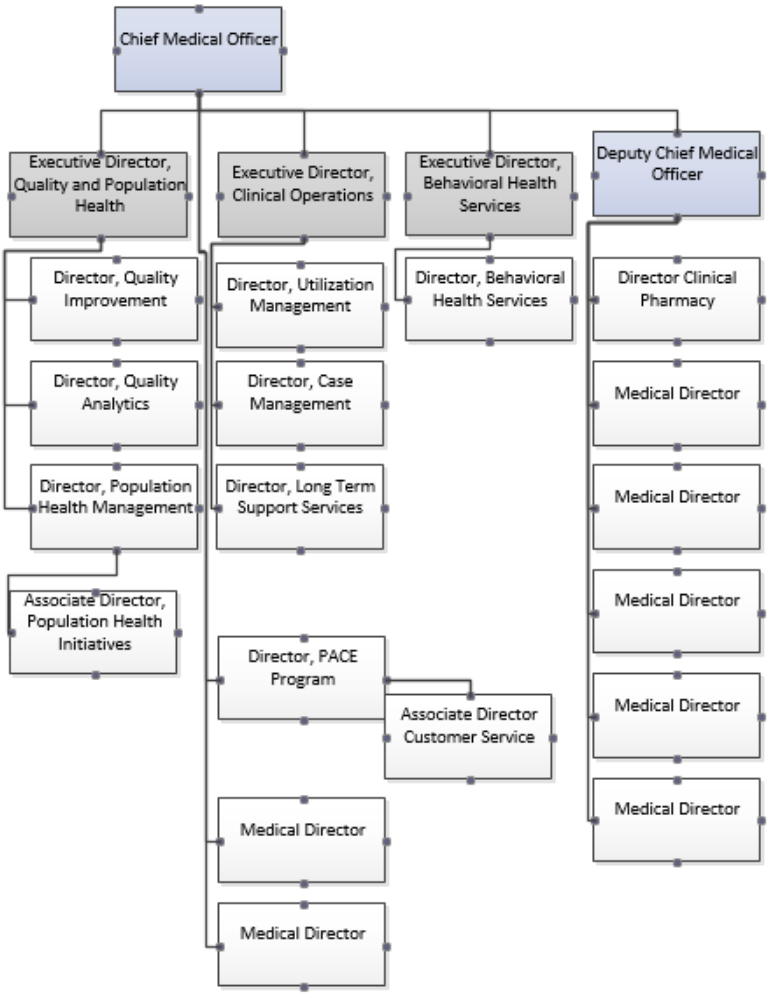
Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan
Do 5) Communicate change plan
6) Implement change plan
Study 7) Review and evaluate result of change
8) Communicate progress
Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement and collaborative 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 QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, medical directors' meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, OCC MAC, WCM FAC and PAC

QUALITY PROGRAM ORGANIZATION STRUCTURE - DIAGRAM



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QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, Information Technology Services 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's CMO and ED, 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 Quality Management functions, including credentialing, FSRs, physical accessibility compliance and working with the ED, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement
- Supervisor, Quality Improvement (PQI)
- Supervisor, Quality Improvement (Nursing Facilities) (CBAS) (FSR)
- Supervisor, Quality Improvement (Credentialing)
- QI Nurse Specialists (RN) (LVN)
- Program Policy Analyst
- Credentialing Coordinators
- Program Specialists (including Intermediate and Senior)
- Program Assistants
- Outreach Specialists
- Auditors

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. 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:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (Pay for Value)
- Manager, Quality Analytics (Network Adequacy)
- Manager, Quality Analytics (Data Analytics)
- Analysts
- Project Managers

- Program Coordinators
- Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agencywide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy Management 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:
- Associate Director, Population Health Initiatives
- Population Health Management Manager (Quality Initiatives)
- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Supervisors
- Program Managers
- Health Coaches
- Registered Dieticians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants

Director, Behavioral Health Integration
Provides program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

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 UM committees and participates in the QIC and the BMSC.

Director, Clinical Pharmacy Management
Leads the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a

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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 P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management
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 (LTSS)
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.

Staff Orientation, Training and Education

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

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, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training

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.

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.

Annual Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected in the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are 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 toward 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 QI activities, including QIPs, PIPs, PDSAs and CCIPs
- 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
- Diagnosis, care and treatment of acute and chronic conditions
- Complex case management: For members with multiple and/or complex conditions to obtain access to care and services via the UM and Case Management departments
- Drug utilization
- Health education and promotion
- Over/underutilization
- 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 regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for 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 ensure 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 department-specific and agencywide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain agencywide practices that support accreditation and meet 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 potential quality of care 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 to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy or GARS, as well as from providers and other external sources.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific 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 recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to, non-physician 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 recredentialing activities for CCN are performed at CalOptima and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and recredentialing of Ops, including, 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 Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing 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 recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate PCP site and medical records review to contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by APL 20-006. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for 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.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 20-006 and CalOptima policies. An Initial Medical Record Review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 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. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or corrective action plan (CAP) follow-up issues.

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

The medical record provides legal proof that the member received care. CalOptima requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and 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 Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant 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 using continuous improvement tools (i.e., quality improvement plans or PDSA) 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 when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI and PHM teams 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 processes and programs to:

- Report, monitor and trend outcomes
- 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 performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QI Program, including, but not limited to, network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS performance
- Member and provider satisfaction surveys

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

POPULATION HEALTH MANAGEMENT

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

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

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

CalOptima developed a comprehensive PHM Strategy that includes a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Plans) will aid the PHM Strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs and CCIPs. Quality Initiatives for 2022 are tracked in the QI Work Plan and reported to the QIC.

In 2022, the PHM Strategy will include greater focus on addressing health inequities and SDOH. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand outreach and initiate new initiatives focused on SDOH and health equity as follows:

- Back-to-school immunization clinics for school-aged children (Tdap, COVID-19 vaccine, etc.)
- COVID-19 Member Health Rewards for CalOptima members, with special focus on those experiencing homelessness
- Improving COVID-19 vaccine access for homebound members and other high-risk populations
- Mobile diaper banks for families of infants and adolescent members in collaboration with Women, Infants & Children (WIC) and the Community Action Partnership
- Improving access for eligible CalOptima members to CalFresh benefits
- Improving access to breast cancer screenings for Korean and Chinese members via mobile mammography
- Remote monitoring for members with chronic conditions
- Escape The Vape (Great American Smoke Out) annual event that offers vape and tobacco prevention to school-aged children
- Shape Your Life Childhood Obesity Program, with group classes to improve awareness of good nutrition and physical fitness for adolescents
- Member Health Needs Assessment

The PHM team also focuses on improvement projects, such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

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

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, 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 remeasurement of quality measures for at least one year after the improved performance has been achieved.

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

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes, but is not 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
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agencywide PHM 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. They are designed to achieve behavioral change and are reviewed on an annual basis. Program topics include exercise, nutrition, hyperlipidemia, hypertension, perinatal health, Shape Your Life/weight management, tobacco cessation, asthma, immunizations and well-child visits.

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.

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 HN providers

Managing Members With Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the PHM program for all 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 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 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, including Health Risk Assessment (HRA) or Health Needs Assessment (HNA) for MOC members.

- 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 evidence-based guidelines distributed to providers who are relevant to chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD).

- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources.

- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary.

- Coordination of services for members for appropriate levels of care and resources.

- Documentation of all findings.

- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness.

- Ongoing assessment of outcomes.

CalOptima's Case Management program includes three care management levels that reflect the acuity of needs: complex case management, care coordination and basic case management. Members within defined MOCs — SPD, WCM, OCC and OC — are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

HRA and HNA

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

ICT

An ICT is linked to 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), depending on the results of the member's HRA and/or evaluation or changes in 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 the member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), case manager, behavioral health specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- 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 Individual Care Plan (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 health status
        - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members — occurs at the HN, or at CalOptima for CCN members.
    - Team Composition: member, caregiver or authorized representative, HN medical director, PCP and/or specialist, ambulatory case manager, hospitalist, hospital case manager 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
            - Care coordination or complex case management
            - Case management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating communication among member, PCP, specialists and vendors
            - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

ICP

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per case management level. The ICP is updated annually and with change in condition.

MOC: Dual Eligible Special Needs Plan (D-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 members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the member'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 for a subset of members 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 members who may be at risk of rehospitalization.

- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and at-high-risk individuals.

- Hospital case management program to coordinate care for members during an inpatient admission and discharge planning.

Care management program focuses on member-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.

Seniors and Persons with Disability (SPD)

The goal of case management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole Child Model (WCM)

The goal of case management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives case management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

CalAIM's Enhanced Care Management (ECM)

Effective January 1, 2022, ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs. These members are among the most vulnerable and highest-need Medi-Cal managed care members. ECM reflects a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch and person-centered. The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social and long-term needs for members. Eligible members may participate in ECM and/or Community Supports through CalAIM.

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. The 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 people 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 who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review and authorization of BHT services.

CalOptima offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

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 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 moderate 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 care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

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

CalOptima is participating in two of DHCS' incentive programs focused on improving behavioral health care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and behavioral health outcomes, care delivery efficiency and member experience. CalOptima is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize behavioral health services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county behavioral health and CalOptima by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OC and OCC

In 2022, OC and OCC behavioral health continues to be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service and subject to medical necessity. Contracts specify that medically necessary services are those that 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 member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2022 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve 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 2022 UM Program Description.

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 members and families are vital members of the health care team.

Member safety is integrated into all components of 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.

This safety program is based on a member-specific 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 risk assessment
- Health education and promotion
- Over/under utilization monitoring
- 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 consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that 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, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety

- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure 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

- Using FSRs, Physical Accessibility Review Survey (PARS) and medical record review results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR 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 postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of flu and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

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    - MRSA prevention program – Shared Healthcare Intervention to Eliminate Life-Threatening Dissemination of Multi-drug Resistant Organisms (SHIELD)

- Administrative offices
    - Fire, disaster and evacuation plan testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include, but are not limited to, face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; and member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print or audio.

The seven most common languages spoken for all CalOptima programs are: English, 59%; Spanish, 26%; Vietnamese, 10%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; and Arabic, less than 1%. CalOptima provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic
- OC member materials are in three languages: English, Spanish and Vietnamese
- OCC member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, 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 our diverse population. 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 MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas
- Improve cultural competency in materials and communications
- Improve network adequacy to meet the needs of underserved groups
- Improve other areas of need as appropriate

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- 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 member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- 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 delegated HNs that are required to meet all contractual, statutory and regulatory requirements, as well as 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's 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 (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Behavioral Health for Medi-Cal, OC and OCC
- 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, and peer review process on specific, referred cases
- Potential Quality Issue investigations
- Development of systemwide 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 recredentialing standards for both practitioners and OPs
- Credentialing and recredentialing of OPs
- 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 2022 Delegation Grid.

See Appendix B — 2022 Delegation Grid

IN SUMMARY

As stated previously, CalOptima 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 members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

APPENDIX A — 2022 QI WORK PLAN

Appendix B — 2022 Delegation Grid

I. PROGRAM OVERSIGHT

A. 2022 QI Annual Oversight of Program and Work Plan
B. 2021 QI Program Evaluation
C. 2022 UM Program
D. 2021 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, OC P4V, Data Mining/Bridge efforts)
M. Improvement Projects (All LOB)PIPs
N. Improvement Projects (All LOB)QIPs
O. Improvement Projects (All LOB)CCIP's
P. PPME/QIPE: HRA's
Q. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
R. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
S. CalAIM
T. Health Equity
U. DHCS Comprehensive Quality Strategy
V. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:

Submitted and approved by QAC: Date:

Quality Improvement Committee Chairperson:

Richard Pitts, D.O., Ph.D Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date:

B. 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.

C. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)

D. Follow-Up After Emergency Department Visit for Mental Illness (FUM)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)

B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

C. Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot

V. QUALITY OF CLINICAL CARE- Maternal Child Health

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

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA

B. Blood Lead Screening (BLS) (LSC)

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Expanding Network of Providers Accepting New Patients
C. Improve Access: Timely Access (Appointment Availability)
D. Improve Access: Telephone Access
E. Improving Access: Subcontracted Network Certification

VIII. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.
B. Post-Acute Infection Prevention Quality Incentive (PIPQI)
C. Orange County COVID Nursing Home Prevention Program.

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT									
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	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 by April 2022	Marsha Choo		X			
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo		X			
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Mike Shook		X			
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Mike Shook		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Marie Jeannis/Kelly Giardina		X			
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Marsha Choo/Laura Guest		X			
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Tyronda Moses		X			
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo		X			
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook		X			
Whole Child Model - Clinical Advisory Committee (WCM CAC) - Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD		X			
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Sandeep Mital		X			

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2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, **OC P4V,** Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures. **[NEW] Development of the OC P4V program for MY2023**	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital		X			
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs **MC PIPs:** 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	Health Equity	X			
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs **MC QIP:** 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD) b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	Health Equity	X			
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on **All LOB CCIPs** 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn		X			
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals **OC and OCC** PPME and QIPEs 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Sloane Petrillo/S. Hickman		X			
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson		X			
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 addition of virtual outreach visits to shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Katie Balderas/Sloane Petrillo	SDOH	X			

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2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Sloane Petrillo/Natalie Zavala	SDOH	X			
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Katie Balderas/Marie Jeannis	Health Equity	x			
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW} to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marie Jeannis/Marsha Choo	Health Equity				
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	[NEW} to 2022 QI Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.	12/31/2022	Natalie Zavala	Health Equity				
II. QUALITY OF CLINICAL CARE- Adult Wellness									
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	Health Equity	X			
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn		X			

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2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health									
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2021 Goal:** FUH 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:34.67%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala		X			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS MY2021 Goal:** MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala		X			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	[NEW} to 2022 QI Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala					
IV. QUALITY OF CLINICAL CARE- Chronic Conditions									
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2021** HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn		X			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn		X			

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2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx.	There are four parts to this multidispclinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care plannin motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (IC meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.	12/31/2024	Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson		X			
V. QUALITY OF CLINICAL CARE- Maternal Child Health									
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	Health Equity	X			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness									
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2021** Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	Health Equity	X			

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2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2021 Goal (3 Year Goal)**: Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn		X			
VII. QUALITY OF SERVICE- Access									
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Michelle Laughlin/Jennifer Bamberg/Maggie Hart		X			
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo/Jennifer Bamberg					
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards 3) See Virtual Care Strategies	12/31/2022	Marsha Choo/Jennifer Bamberg		X			
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After 3 Attempts** from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg		X			
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo/Jennifer Bamberg					

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2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VIII. SAFETY OF CLINICAL CARE									
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	**HEDIS MY2021** Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving inctreased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regardign the importance of having a post dischage visit with the members PCP.	12/31/2022	Mike Shook		X			
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) To reduce the number of nosocomial infections for LTC members. 2) To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses will be visiting each facilitiy/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofor (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	12/31/2022	Michelle Findlater/Scott Robinson		X			
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities; toolkit, consultative services and webinars provided to all Orange County nursing homes free of charge	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2022. Planned activities include: 1) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 2) Provide guidance, protocols for preventing spread of COVID 3) Support training on how to stock and use protective gear 4) Develop high compliance processes for protection of staff and residents. 5) Make toolkit available for free at www.ucihealth.org/stopcovid 6) Provide COVID prevention helpline to offer guidance and information to nursing home staff 7) Conduct point prevalence sweeps of residents for multi-drug organisms	5/31/2022	Cathy Osborn/**Scott Robinson**		X			

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APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
New	QI1E: Promoting Organizational Diversity, Equity and Inclusion	X		X	[NEW] Effective 7/1/2022, 2022 HP Standards
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	
2.2.4	PHM2D: Segmentation-PHM	X		X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X	X	X	
3.4.2	NET4B: Continued Access to Practitioners	X	X	X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA (Interim Surveys only)
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				For Medi-Cal or OC/OCC this function or activity is not Applicable
4.9.6	UM9F: Appeals Overturned by the IRO				For Medi-Cal or OC/OCC this function or activity is not Applicable
4.9.7	Provider Level 1 UM Appeals	X	X	X	
4.9.8	Provider Level 2 UM Appeals	X			
4.10.1	UM10A: Written Process	X			For Medi-Cal, this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
4.10.2	UM10B: Description of the evaluation Process	X			For Medi-Cal, this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
~~4.11.1~~	~~UM11A: Pharmaceutical Management Procedures (Policies and Procedures)~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.2~~	~~UM11B: Pharmaceutical Restrictions/Preferences~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
~~4.11.3~~	~~UM11C: Pharmaceutical Patient Safety Issues~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.4~~	~~UM11D: Reviewing and Updating Procedures~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.5~~	~~UM11E: Considering Exceptions~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
4.12.1	UM12A: UM Denial System Controls	X	X	X	
New	UM12B: UM Denials System Controls Oversight	X	X	X	[NEW] Effective 7/1/2022, 2022 HP Standards
4.12.2	UM12C: UM Appeal System Controls	X		X	
New	UM12D: UM Appeals System Controls Oversight	X		X	[NEW] Effective 7/1/2022, 2022 HP Standards
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
4.14.1	Second Opinion	X	X	X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	
New	CR1D: Credentialing System Controls Oversight	X	X	X	[NEW] Effective 7/1/2022, 2022 HP Standards
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				For Medi-Cal, this standard is not applicalbe because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activities is retained by CalOptima and is not delegated to the Delegate.
5.7.4	CR7D: Assessing Medical Providers	X	X	X	
5.7.5	CR7E: Assessing Behavioral Healthcare Providers	X			For Medi-Cal, this standard is not applicable because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activities is retained by CalOptima and is not delegated to the Delegate.
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	

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Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations	X			For Medi-Cal , this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.3.2	ME3B: Communication with Prospective Members	X			For Medi-Cal , this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.3.3	ME3C: Assessing Member Understanding	X			For Medi-Cal , this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.4.1	ME4A: Functionality: Website	X			Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X			Not Required for Renewal Survey
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	

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2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated

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APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Timeliness of Claims Processing	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR) related to Claims Payment Decisions- Level 1	X	X	X	
7.1.7	Provider Dispute Resolution related to Claims Payment Decisions- Level 2	X			
7.1.8	Third Party Liability (TPL)	X	X	X	
8.1.1	Provider Complaint Processing	X			

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
9.1.1	MED1H: Notification of Termination of a Practitioner or Practice Group	X		X	
9.2.1	MED2A: Adoption of Practice Guidelines	X		X	
9.2.2	MED2B: Distributions of Practice Guidelines	X		X	
9.3.1	MED3B: Site Visits and Ongoing Monitoring	X		X	
9.4.1	MED5A: Coordination Health Care Services for Members	X	X	X	
9.4.2	MED5B: Maintaining and Sharing Member Health Records	X		X	
9.5.1	MED8D: Informing Members About the QI Program	X		X	
9.6.1	MED9D: Affirmative Statement about Incentives	X		X	
9.7.1	MED12D: Providing Information to Medicaid Members in the Practitioner Directory	X		X	
9.7.2	MED12F: Providing Information to Medicaid Members in Denial Notifications	X		X	
9.7.3	MED12G: Providing Information to Members in Appeal and Grievance Notifications	X		X	
9.7.4	MED12H: Interpreter Services for Medicaid Members	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
9.7.5	MED12I: Usability Testing of Member Materials	X		X	
9.8.1	MED13B: Offering Special Communication Assistance	X		X	
9.9.1	MED14A: Directory Data	X		X	
9.9.2	MED14B: Pharmacy Directory Data	X		X	
9.9.3	MED14C: Behavorial Healthcare Directory Data	X		X	
9.9.4	MED14D: Long-Term Services and Supports Provider Directory Data	X		X	
9.10.1	MED15A: Delegation Agreement	X			May not be Delegated
9.10.2	MED15B: Provisions for PHI	X			May not be Delegated
9.10.3	MED15C: Predelegation Evaluation	X			May not be Delegated
9.10.4	MED15D: Review of Delegates MED Activities	X			May not be Delegated
9.10.5	MED15E: Opportunities for Improvement	X			May not be Delegated
Note: NCQA Delegated Elements are based on 2021 HP Standards. QI1E, UM12B,UM12D, CR1D are new to 2022 HP Standards (will be added new Delegation Agreements in 2022)					

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Better. Together.

2021 Quality Improvement (QI) Evaluation, 2022 QI Program and Work Plan

Quality Assurance Committee
March 9, 2022

Marie Jeannis, RN, MSN, CCM, Executive Director, Quality & PHM
Marsha Choo, Interim Director, Quality Improvement

QI Program, Workplan and Evaluation

- Annually, CalOptima evaluates the effectiveness of the QI Program:
  - Achievements from the previous year
  - Program structure
  - Responsibility of initiatives
  - Identification of new initiatives
- Based upon the evaluation of the previous year, the QI Program is revised and updated for the following year.
- The QI Workplan provides the detail of how CalOptima will design, implement and measure the initiatives outlined in the QI Program.
- In 2022, QI Workplan has been updated to flag activities related to health equity

2021 QI Program Achievements

Date	Awards and Recognition
July 2021	Achieved NCQA[1] Accreditation through 2024
September 2021	Received 4 out of 5 in NCQA's Medicaid Health Plan rating
September 2021	Received mPulse award for Achieving Health Equity related to health care innovation
September 2021	Received Orange County Chapter of the Public Relations Society of America's Award of Excellence for COVID-19 response
October 2021	CalOptima PACE program recognized by Assemblywoman Cottie Petrie-Norris for use of telehealth technology
November 2021	Received DHCS[2] 2021 Consumer Satisfaction Award – Adult (for large scale health plan)

NCQA[1] - National Committee for Quality Assurance
DHCS[2] – Department of Health Care Services

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2022 QI Program Recommendations

- Incorporate SDOH[1] and health equity in targeted quality initiatives.
- Collaborate with external stakeholders and partners in the comprehensive assessment of our members.
- Develop robust community-based interventions using analytical tools, such as geomapping.
- Strategize and streamline member outreach by using multiple modes of communication
- Expand collaboration on quality initiatives with health networks.
- Implement ECM[2] and Community Supports as part of CalAIM[3].
- Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic.
- Align QI Program with DHCS 2022 Comprehensive Quality Strategy

SDOH[1] – Social Determinants of Health
ECM[2] - Enhanced Care Management
CalAIM[3] - California Advancing and Innovating Medi-Cal

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2022 QI Goals and Initiatives

- Goals:
  - Develop and implement a comprehensive Health Equity framework
  - Ensure member's safety during COVID-19 pandemic
  - Improve member quality of care and experience
  - Engage providers through the provision of new pay for value (P4V) program
- Outreach and engagement activities:
  - CalFresh Outreach Strategy
  - COVID- 19 Vaccination events for new age groups and boosters
  - Mobile Mammography Clinics
  - Orange County Diaper Bank events
  - Back to School Wellness Adolescent Health Immunization Clinic
  - Great American Smokeout per American Cancer Society
  - Diabetes Care Program

2022 QI Program Appendix

- Appendix A – 2022 QI Workplan
  - Additions to workplan in red font
- Appendix B – Delegation Grid
  - CalOptima Responsibilities
  - Activities Delegated to Health Networks
  - Activities Delegated to Kaiser

Our Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 9, 2022
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

4. Receive and File 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2022 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Monica Macias, LCSW, PACE Director, (714) 468-1077

Recommended Actions

- Receive and File 2021 CalOptima PACE Quality Improvement Plan Evaluation, and
- Approval of the 2022 PACE Quality Improvement Plan

Background

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. As of December 31, 2021, CalOptima PACE has 421 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 and participant satisfaction.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is evaluated annually. The results of the evaluation can directly lead to the revisions made to the following year's QI Plan. The QI Plan reflects the full range of services furnished by CalOptima PACE. The goal of the QI 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 2021 Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation analyzes the core clinical and service indicators to determine if the 2021 Plan has achieved its key performance goals for the year. In 2022, CalOptima PACE continues to expand participants services and update quality element goals to include vaccinations, improved telehealth options, and continued efforts to ensure comprehensive care. The 2022 PACE Quality Improvement Plan reflects our efforts to continue a high level of quality while also focusing on improving health outcomes and access for our program participants.

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Discussion

In 2021, the continued COVID-19 pandemic held challenges which significantly impacted CalOptima PACE. PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus. The pandemic led to an increase in the utilization of telehealth as PACE continued HIPPA compliant telehealth solutions this year. Additionally, as a quality element PACE was able to assist 96% of participants in becoming fully vaccinated against COVID-19. Despite COVID-19, the PACE program was still able to meet 25 of the 29 quality work plan goals while also increasing participant satisfaction scores.

CalOptima PACE has updated the 2022 Quality Improvement Work Plan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner. The 2022 PACE Quality Improvement Plan, created through a collaboration of the PACE Leadership team, refines the PACE Quality elements based on the current population's health needs. The 2022 PACE Quality Improvement Plan challenges the PACE team to strive for improvement in areas of treatment, service, and health outcomes.

In 2022 PACE proposes:

1. To add an element focused on the treatment of Osteoporosis in order to slow down bone loss, lower risk of fracture, and help with pain management.
2. To ensure that our eligible participants receive their COVID-19 vaccine boosters to prevent infection and hospitalization.
3. To continue to strive for Medicare Quality Compass HEDIS 95th percentiles for our diabetic care elements.
4. To assist in providing our participants with completed advanced health care directives.
5. To improve access to telehealth options for our participants to make healthcare services more readily available and convenient.
6. To focus on preventing falls with injury among our participants.
7. To continue to provide excellent service to our participants in areas of transportation, meals, and overall satisfaction with the PACE program.

Rationale for Recommendation

PACE organizations are required to establish a QI program. Through the Code of Federal Regulations (CFR), 42 CFR section 460.130 (a), the Centers for Medicare & Medicaid Services (CMS) requires a PACE organization must develop, implement, maintain, and evaluate an

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effective, data-driven quality improvement program. As per 42 CFR section 460.132(a) and (b), A PACE organization must have a written quality improvement plan that is collaborative and interdisciplinary in nature. The PACE governing body must review the plan annually and revise it, if necessary.

Fiscal Impact

The recommended action to approve the 2022 PACE QI Plan has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2021-22 Operating Budget. Staff will include updated expenditures for the period of July 1, 2022, through December 31, 2022, in the FY 2022-23 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2021 CalOptima PACE QI Program Evaluation
2. 2022 PACE Quality Improvement Program and Work Plan (Redline version)
3. Proposed 2022 Quality Improvement Program and Work Plan (Clean version)
4. PowerPoint Presentation: 2021 PACE QI Work Plan Evaluation, 2022 PACE QI Work Plan

/s/ Michael Hunn *03/04/2022*
Authorized Signature **Date**

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CALOPTIMA PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

2021

QUALITY IMPROVEMENT PLAN

ANNUAL EVALUATION

SIGNATURE PAGE

PACE Quality Improvement Committee Chairperson:

_____ _____

Richard Helmer, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

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

Board of Directors Chairperson:

_____ _____

Andrew Do **Date**
Supervisor, First District

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2021 CalOptima PACE

Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

As the COVID-19 pandemic continued into 2021, unprecedented challenges continue to impact all areas of life. CalOptima PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus.

When the pandemic was first declared, the scope of delivery of health care services had to instantly adjust to numerous health orders and recommendations from the national, state and county levels. We have continued to closely follow all updated mandates to provide a safe environment for our staff and participants.

PACE along with others in the health care community, received a waiver from the Centers for Medicare & Medicaid Services (CMS), to provide the flexibilities needed to take care of patients during the continued public health emergency. This has improved our ability to provide services beyond the existing walls of the PACE Center and assume a more home-based model, called "PACE without Walls." We continued with our service delivery matrix to provide existing PACE care services including: medical management, nursing services, social services, therapies such as physical, occupational and speech therapies, dietary services and personal care services. Additional "PACE without Walls" services delivered by our transportation team included care packages containing items such as activity books, calendars, and socks. Participants eagerly awaited these care packages and the opportunity to connect with others beyond their home.

The PACE Clinic continued operations and a new triage system was used to accommodate requests from our participants for urgent and same day visits with our medical providers. Understanding the importance of continuing to provide preventive health services, we continued drive-through immunization hours and drive-through COVID-19 testing. In January and February of 2021, the PACE center was able to hold several vaccinations events at PACE in which participants were offered the Moderna vaccine provided in collaboration with Orange County Health Department and Mercy Pharmacy. Additionally, a collaboration between the PACE clinic, the Quality Improvement department and the PACE scheduling team led to additional COVID vaccinations. These events were extremely successful, and we were able to end 2021 with a 96% participant COVID-19 vaccination rate. Additionally, efforts began in Q4 to provide eligible participants with third dose/boosters as recommended.

Understanding the profound importance of maintaining contact with PACE participants, we continued with our previously implemented "wellness calls" to check in on the well-being of our participants. As of the end of 2021, close to 30,000 wellness calls have kept participants connected with PACE since the start of the pandemic.

In July of 2021, after several months without any new reported cases, the PACE center reopened for limited day center services. This reopening was small scale, with only up to 12 participants per day on Mondays through Thursdays, AM shift only. All CDC guidelines were put into place to ensure safety protocols are being followed. Four "pods" were assigned in the day floor area, with two staff members per pod. Participants were chosen by IDT based on who needed the most

support and who was able to follow the CDC guidelines (i.e., wear a mask, stay 6 feet apart). Any participants attending day center services must also be fully vaccinated, which now includes booster doses. Additionally, in Quarter 2 and 3, we were able to provide more face-to face services for participants with their providers, clinic, and rehabilitation staff. Unfortunately, toward the end of Quarter 4 we began to see an uptick in cases of COVID-19 and made the difficult decision to put non-emergent services on hold temporarily until this most recent surge has passed.

Despite the challenges of COVID-19 we continued to enroll new participants and saw our highest enrollment number ever in 2021. When CalOptima PACE opened for operations on October 1, 2013 we had 13 participants. We have seen steady growth in enrollment through the years and at the end of 2021, we had 421 participants enrolled. The multi-cultural background and the diversity of our participant population provides a very vibrant and engaging environment. Out of our 421 participants, the preferred languages are 60% Spanish, 19% English and 17% Vietnamese. Other languages spoken include Arabic, Korean, Tagalog, Chinese, Hindu, Persian and Telugu.

The purpose of the CalOptima PACE QI 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 QI 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 QI 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 2021 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2022 PACE QI Plan.

SECTION 1: PROGRAM STRUCTURE

The CalOptima PACE QI Plan is developed by the PACE QI 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 2021 PACE QI Plan was reviewed and approved by the CalOptima Board of Directors on February 25, 2021.

The CalOptima PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI manager will ensure timely collection and completeness of data with the support of the PACE QI program specialists. Overall, oversight of the PACE QI is provided by the CalOptima Board of Directors.

The CalOptima PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima's PACE participants.

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters 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 QI activities carried out on an ongoing basis to ensure that quality of care issues are identified and corrected.

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2021, CalOptima PACE accomplishments include:

1. Swift response to updates regarding the COVID-19 pandemic, to follow all federal, state, and local guidance.
2. Continued a clinic triage system to provide health care access to participants during the ongoing pandemic.
3. Use of various telehealth modalities that enabled participants to "visit" their providers from their homes.
4. Implemented comprehensive care coordination activities to ensure that participants received the COVID-19 vaccination as well as COVID-19 booster vaccines.
5. Connected with participants through 9946 wellness calls, 40,268 home delivered meals and provision of 3851 care packages throughout 2021.
6. Provided aggressive infection control training to all staff in accordance with CDC, DHCS and CDPH directives.
7. Oversight of PACE contractors to ensure compliance to state and federal COVID-19 vaccination guidelines.
8. Implemented robust staff COVID-19 vaccination compliance, assuring that staff was fully vaccinated by the state ordered deadline of September 30, 2021.
9. Implemented robust participant COVID-19 vaccination initiative, with 96% of participants becoming fully vaccinated by the end of 2021.
10. Formulated and implemented a plan to re-open PACE Day center activities on a limited basis in accordance with infection control guidelines.
11. Established COVID-19 visitor vaccination protocols, which included proof of vaccination for those accessing the PACE Center.
12. Implemented COVID-19 rapid antigen testing for unvaccinated caregivers who accompany participants for PACE services.
13. Continued deployment of staff to work remotely from their homes when possible.
14. Weekly COVID-19 updates to the leadership team and monthly updates during our all-staff meetings.
15. Completed two Quality Initiatives: COVID-19 Vaccine Quality Initiative and Telehealth Engagement Initiative.
16. Met 25 out of 29 Work Plan goals.
17. 91% of participants received their annual influenza vaccine.
18. 94% of participants received the Pneumococcal vaccine.
19. Continued enhanced care coordination program for participants with dialysis.
20. 100% of participants had their medications reconciled within 30 days of hospital discharge.
21. Prompt review by clinical pharmacist of specialty medications ordered by outside specialists.
22. Retrospective reviews of medication utilization were performed daily and monthly. Recommendations were immediately addressed with the PACE provider and/or IDT.
23. Quality of Diabetes Care
    a. 95% of participants with diabetes completed an annual eye exam.

b. 100% of participants with diabetes had nephropathy monitoring.
c. 89% of participants with diabetes had their blood pressure controlled.

24. Utilization:
    a. Only 2.8% participants were placed in long-term care in 2021.
    b. Refined the PACE Emergency Room (ER) Diversion program.
    c. Continued to provide in-house specialists including podiatry and dental for improved access and coordination of care.
    d. Added psychiatrist and nephrologist to list of on-site specialty care providers.
    e. Morning clinical huddles continue to be incorporated into the IDT meetings for all teams.
25. Transportation:
    a. 30,696 one-way trips with an on-time performance of 99%.
26. Participant Satisfaction
    a. 91% overall satisfaction with care received compared to the national average of 88.5%.
    b. 95% said the services they received at PACE improved or maintained their quality of life.
    c. 94% said they would recommend the program to a close friend.
    d. 8 of the 10 participant satisfaction domains scored higher than the national average.
27. 100% of staff competency assessments were completed. Year-round staff trainings were provided covering a broad area of topics included coding, infection control, wound care, emergency responses, grievances, appeals, service delivery requests, and participant rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, care, and utilization. Accomplished and evidenced by:
    a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. The ongoing PACE QI activities and initiatives.
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. Accomplished and evidenced by:
    a. The ongoing HPMS and QI individual metric data collection and analysis.
    b. The ongoing PACE QI initiatives.
    c. The monitoring of member grievances and complaints, and regular review of delegated entities.
    d. The monthly meeting with the transportation vendor.
    e. The daily morning inpatient and nursing facility clinical reviews.
    f. 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. The annual approval of up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
i. The Redesigned PACE Clinic Workflow/Triage to efficiently address participant care issues during the COVID-19 pandemic.
j. Continuation of telehealth platform that enables enhanced access to care during the pandemic.
k. Updated the relative value unit (RVU) measurement to monitor the productivity of clinic staff, including those deployed as teleworkers.

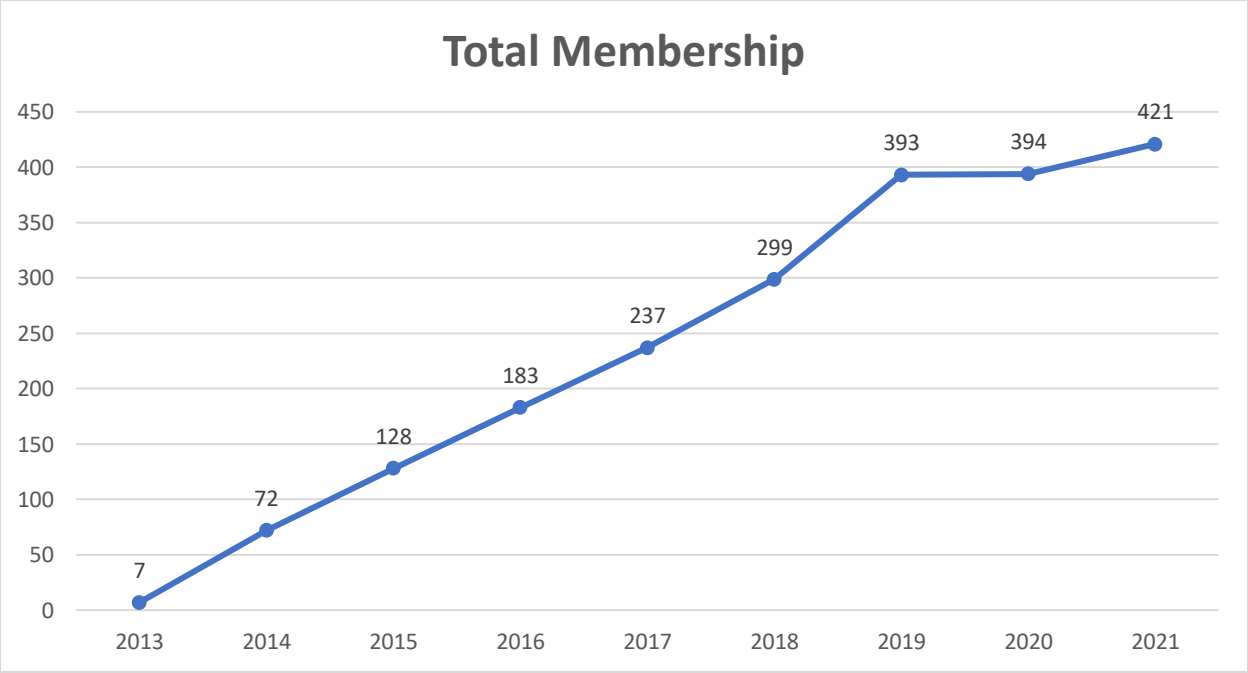
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners. Accomplished and evidenced by:
    a. The Interdisciplinary Care Team (IDT) meetings at CalOptima PACE.
    b. Continued presence of physicians during IDT meetings.
    c. Addition of preferred specialists who regularly provide services within the PACE clinic.
    d. The coordination of care found in 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. Accomplished and evidenced by:
    a. The number of grievances that have been tracked and trended.
    b. A nurse practitioner that specializes in podiatric procedures, and a dentist at the PACE clinic to see and treat the PACE participants.
    c. Addition of nephrologist and psychiatrist to specialist staff providing on-site care.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service. Accomplished and evidenced by:
    a. The credentialing and peer review process.
    b. Annual evaluations of all CalOptima PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances. Accomplished and evidenced by:
    a. The improvements in the PACE Participant Satisfaction Survey.
    b. The summary of grievance and appeals activities.
    c. The ongoing input from the PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes. Accomplished and evidenced by:
    a. The QI activities which occur around all Unusual Incidents, including root cause analyses.
    b. Physical therapy driven groups such as Fall Prevention Group, Fallers Anonymous and Matter of Balance groups.
8. Compliance with regulatory agencies and accreditation standards. Accomplished and evidenced by:
    a. The successful submission of data as required by CMS and DHCS.
9. Compliance with clinical practice guidelines and evidence-based medicine. Accomplished and evidenced by:
    a. The adoption of the National PACE Association Preventative Guidelines.
    b. The use of Uptodate.com clinical practice standards.
    c. On-going PACE staff training.

10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently. Accomplished and evidenced by:
    a. Tracking, trending, and analyzing utilization management (UM) data monthly.
    b. The provider incentive program.
    c. The coordination of care found in the ER Diversion Program.
    d. The weekly PACE leadership team meetings.
    e. The participation in the CalOptima QI, UM, and Credentialing and Peer Review Committee meetings.
    f. The participation in the CalOptima Board of Directors and the Board of Directors' Quality Assurance Committee meetings.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS

PACE Membership at a Glance

CalOptima PACE offers a community-based program that provides all necessary medical care coordination and social services support in one location to the frail and elderly within our community. The goal of keeping seniors healthy in their homes and maintaining their independence continues to be our mission eight years later. At the end of 2013, we had seven participants enrolled and now, eight years later, we have 421 active participants.



As illustrated in the first membership graph, PACE has seen a steady enrollment trend over the years. 2018 was a particularly notable year for enrollment, as this was the year we implemented "PACE 2.0" a collaborative PACE-team effort focused on program growth and expansion. The tenets of PACE 2.0 were to create a context for change by developing a process for optimizing enrollment and establishing organizational capacity to promote continued growth. Due to the

COVID-19 pandemic, there was almost no growth noted in 2020. However, despite continued challenges, in 2021 PACE again saw an upward trend in enrollment numbers.

In 2022, our goals for program growth remain intact and strategies are already being put into place to accommodate participants post-pandemic. We continue to plan for aggressive marketing which includes 2022 rebranding efforts as well as print, radio and television media to reach a wider audience throughout Orange County.

2021 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI21.01 PACE QAPI Plan and Work Plan will be evaluated annually

Received and filed by the CalOptima Board of Directors on February 25, 2021.

QI21.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Board of Directors on February 25, 2021.

QI21.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their annual influenza vaccination by December 31, 2021.

Goal: Not Met

Data/Analysis: 91% percent of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

With a year-end vaccination rate of 91%, we fell short in meeting our goal by three percentage point. This was despite an aggressive flu vaccination campaign which included drive through vaccine clinics at PACE. All participants who have not been vaccinated have had discussions with our providers and have refused. Vaccines were pre-ordered in late spring from our distributer, and

we began to vaccinate participants when vaccines arrived in mid-August. Monthly reports were generated by our QI department identifying those participants who still required the vaccine, and this was shared with the PCP and RN's who personally reached out to the unvaccinated participants. 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.

PACE staff also received their flu vaccine through employee health services, expanding the scope and engagement of the flu vaccine campaign. It is important to note that CalOptima PACE reported zero influenza outbreaks among our participants or staff in 2021. Our 2021/2022 influenza vaccination efforts will continue through Quarter 1 of 2022 where we will continue to reach out to the unvaccinated.

QI21.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their PCV23 pneumococcal vaccination by December 31, 2021.

Goal: Met

Data/Analysis: 94% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2021, 94% of our participants had received the pneumococcal vaccine, meeting our goal. Much of our success is attributed to the implementation of the following protocols:

a. Standing orders and standardized procedures in vaccine administration. This eliminated the need to wait for a physician order by delegating this responsibility to a registered nurse who has demonstrated the required competency.

b. Utilize the electronic medical record's (EMR) quality analytics, and other data platforms to track missed opportunities for immunization.

c. Continued drive-through vaccination clinics.

d. PACE PCP's reached out to those participants who refused the vaccine.

The PACE QI department provided detailed monthly reports which specified which participants still needed the vaccination. It was then shared with all participant's medical providers. As with previous years, one of our challenges was the complex interval periodicity between the Pneumococcal 13 and Pneumococcal 23 vaccines. 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. In 2022, we plan to continue with our successful existing strategies to meet our goals for the pneumococcal vaccine.

QI21.05 Increase COVID-19 immunization rates for all eligible PACE participants

Goal: Greater than or equal to 80% of eligible participants will have their COVID-19 vaccination by December 31, 2021

Goal: **Met**

Data/Analysis: 96% of participant received COVID-19 vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2021, 96% of PACE participants received either 1 dose of Janssen or 2 doses of Moderna or Pfizer COVID-19 vaccine. Much of our success is attributed to the implementation of the following efforts:

a. PACE partnered with Mercy Pharmacy to provide vaccine events for participants within the PACE center in January and February of 2021.

b. PACE PCP's reached out to those participants who initially refused the vaccine to provide education and encouragement.

c. PACE participants who were unable to attend the vaccine events at PACE were tracked and assisted by PACE staff with scheduling of vaccine and transportation to and from vaccination sights.

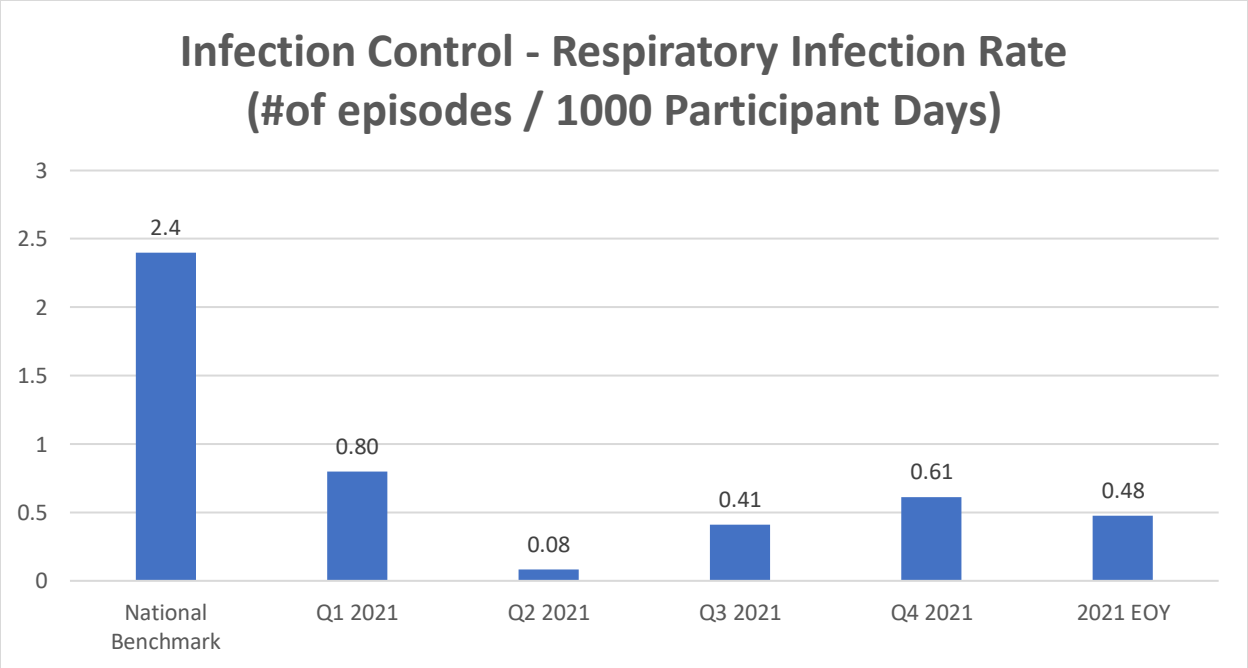
The PACE QI department provided detailed weekly reports which specified which participants still needed the vaccination. These participants were followed up by PCP, QI team and scheduling department to ensure that there were no barriers to vaccination. In 2022, we plan to continue our efforts to ensure that all PACE participants are vaccinated against COVID-19 and have raised our goal to 95% full vaccinated. We will also have a quality initiative to ensure that our participants will be receiving COVID booster shots as well.

QI21.06 Reduce common infectious in PACE participants (Respiratory Infection)

Goal: Maintain common respiratory infection rate less than the following national benchmarks: Respiratory Tract 0.1–2.4 episodes/1000 participant days.

Goal: Met

Data/Analysis: The 2021 rate was 0.48 episodes per 1000 participant days.



Summary and Key Findings/Opportunities for Improvement:

Despite the COVID-19 pandemic, we were able to conclude the year below the national benchmark. As in previous years, we focused heavily on infection control in 2021 with increased

surveillance due to continued COVID-19 pandemic. In 2021, we limited day center on-site activities for participants and continued to enable eligible staff to telework. We screened all individuals accessing the PACE center and continued the mask mandate for all individuals at the center. We ordered and tracked our personal protective equipment (PPE) inventory and continued our enhanced environmental controls such as surface disinfection. We continued our comprehensive infection control training which covered blood borne pathogens, droplet vs. aerosol COVID-19 transmission, handwashing, and proper use of PPE. We continued to follow the guidance of Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency and continued conducting drive thru COVID-19 testing for our participants who were symptomatic. All positive COVID-19 participants received daily phone calls from their PCP and ancillary health staff. We also included an aggressive campaign to vaccinate participants with the two pneumococcal vaccines, PCV13 and PPSV23. Other actions taken to minimize the risk of respiratory infections were interventions such as providing home nebulizer machines to participants with COPD, CHF and asthma. Keeping abreast of the trending of the COVID-19 virus and anticipating surges allowed us to plan for the "worst case scenarios" and implement a solid infection control plan and to maintain a safe environment for our participants and staff members. The PACE leadership team has recommended to sunset this element due to consistently meeting the benchmark for the past 3 years.

QI21.07 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

Goal: Greater than or equal to 95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2021.

Goal: Not Met

Data/Analysis: 91% of participants enrolled in the PACE program for 6 months had POLST by the end of 2021.

Quarter 2021	Completion Rate
Q1	89%
Q2	90%
Q3	94%
Q4	93%
EOY	**91%**

Summary and Key Findings/Opportunities for Improvement:

We did not meet our goal in 2021. With the continuation of COVID-19 pandemic, the one-on-one encounter necessary for a POLST completion was not feasible. However, end-of-life care which is consistent with the participants wishes are still reviewed with the participant and the PCP during telehealth encounters. End-of-life and palliative care discussions continue to be integrated into our Interdisciplinary Team meetings (IDT) and are documented in the participant's care plan.

In 2022, we plan to continue our efforts to ensure that our participants have a POLST in place. In addition to the PACE Clinical Operations Manager having oversight of this element, the PACE Clinical Medical Director will also be assisting with plans to reach our goal in 2022.

QI21.08 Increase the percent of PACE participants who have an Advance Health Care Directive

Goal: Greater than or equal to 40% of eligible participants will have an Advance Health Care Directive in place by December 31, 2021

Goal: **Met**

Data/Analysis: 43% of participants had an Advance Health Care Directive by December 31, 2021.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2021, 43% of PACE participants had completed an Advance Health Care Directive, meeting our goal. The leadership team has agreed that we will continue support this project as a quality initiative in 2022. The PACE leadership team has completed a plan to increase the number of participants who have Advance Health Care Directives on file. The PACE Center Manager with assistance from the Social Work Department will implement this plan with a goal of ≥ 50% of participants with completed AHCD by the end of 2022.

QI21.09 Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS

Goal: 100% of participants have functional status assessment completed every 6 months by the disciplines required by CMS.

Goal: Met

Data/Analysis: 100% of participants had functional assessment completed every 6 months.

Functional Status Assessment	Q1 2021	Q2 2021	Q3 2021	Q4 2021	EOY
Charts with All Assessments	387	398	409	419	1613
Census at End of Quarter	387	398	409	419	1613
Rate	**100%**	**100%**	**100%**	**100%**	**100%**

Care for Older Adults: Functional Status Assessment				
	2021 Star Rating Measure Cut Points			
MY 2021 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	55% to 71%	71% to 85%	85% to 93%	**≥ 93%**

Summary and Key Findings/Opportunities for Improvement:

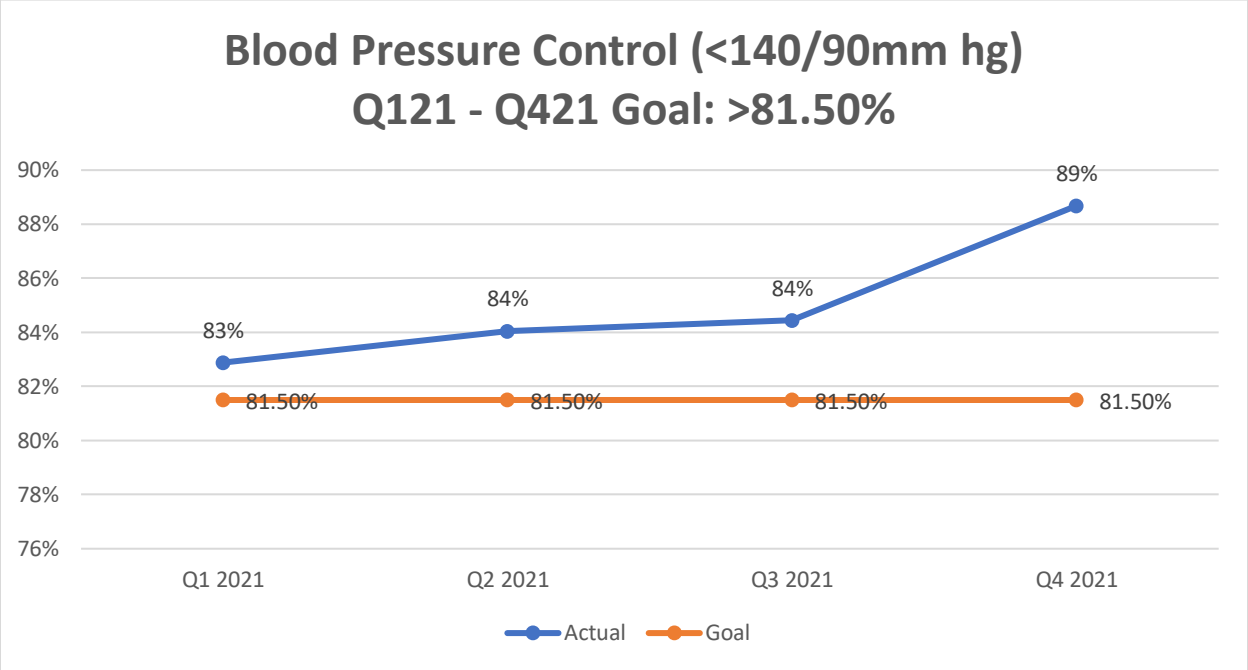
Annual and semi-annual functional assessments are critical in determining a participant's medical, psychosocial, and cognitive status. These assessments assist in identifying risk factors and interventions necessary for optimal outcomes. A key factor in achieving this has been the monthly reports generated by the QI department specifying which participants required the functional assessment. This prompts the IDT disciplines to schedule the appointment, communicate with the family/caregiver regarding the appointment and coordinate transportation for the participant. Our success in this element places us comparable to a 5-Star Medicare rating based on the 2020 Star Rating Measure Cut Points. PACE has maintained this element continuously at 100% and it is a core regulatory requirement that is tracked elsewhere and therefore the leadership team has elected to remove this as a quality measure in 2022.

QI21.10 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: > 81.50% of Diabetics will have a Blood Pressure of <140/90

Goal: Met

Data/Analysis: The 2021 final rate was 89%.



Diabetics with Controlled Blood Pressure					
	2019 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
89%	64.72%	69.53%	76.56%	81.50%	**84.91%**

Diabetes Care: Blood Sugar Controlled				
	2021 Star Rating Measure Cut Points			
MY 2021 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
89%	37% to 61%	61% to 72%	72% to 85%	**≥ 85%**

Summary and Key Findings/Opportunities for Improvement:

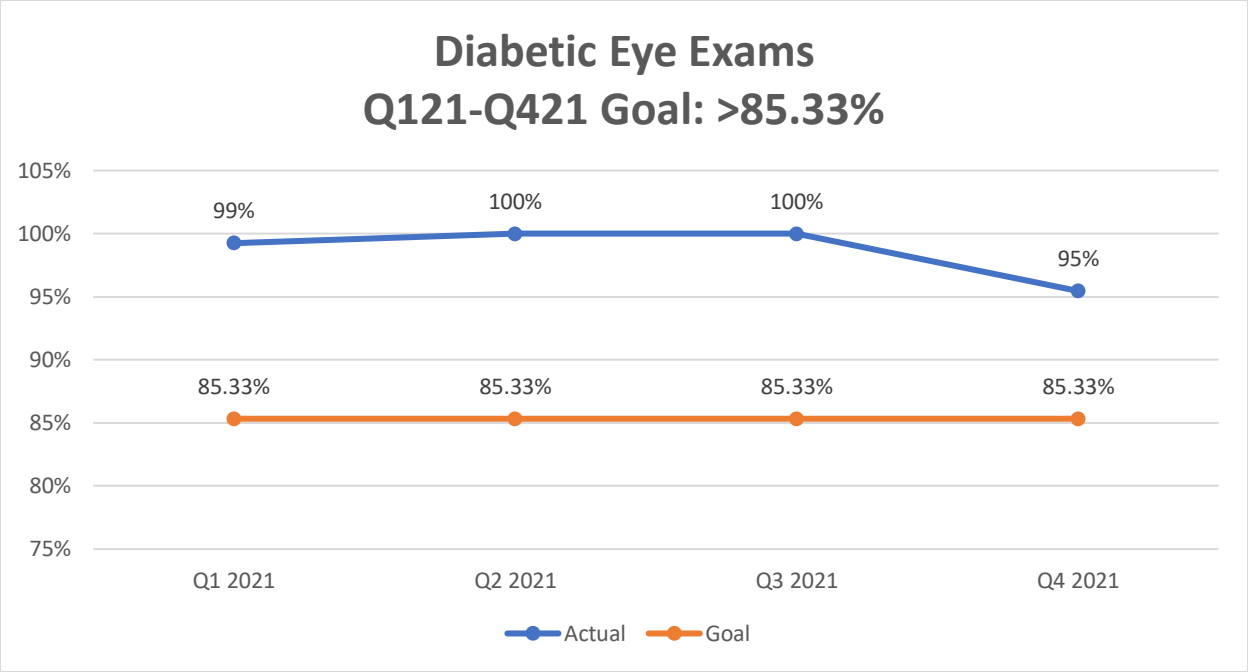
We exceeded our goals in this element and increased our performance by 2 percentage points from 2020. Prompt identification of participants with poor control of their blood pressure and monthly generated reports contributed to the success in this element. Those participants with out-of-range numbers are monitored leading to direct interventions such as medication adjustments. Our in-house pharmacist also provided recommendations for those participants who have difficulty maintaining adequate blood pressure control. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile and a 5-star Medicare rating based on 2021 Star Cut Points. We will maintain this goal and continue our successful monitoring plan in 2022.

QI21.11 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than 85.33% of Diabetics will have an Annual Eye Exam

Goal: Met

Data/Analysis: The 2021 final rate was 95%.



Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
	2019 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
95%	67.75%	75.28%	82.00%	85.33%	**87.10%**

Diabetes Care: Eye Exam					
	2021 Star Cut Points				
MY 2021 PACE	1 Star	2 Stars	3 Stars	4 Stars	**5 Stars**
95%	<63%	63% to 69%	69% to 73%	73% to 78%	**≥ 78%**

Summary and Key Findings/Opportunities for Improvement:

We exceeded our target goal, with 95% of diabetic participants having received an annual eye exam in 2021. With the assistance of monthly reports generated by the PACE QI team, medical providers were alerted to those participants who required eye exams. Those participants were then scheduled for an appointment with their PCP on an annual and semi-annual basis. Contracted ophthalmologists and optometrists are very diligent in their follow-up and provide our medical team with timely specialty reports. These results are comparable to a 5-Star Medicare rating based on the 2021 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95% percentile. In 2022, the goal will be changed to >82.77% of Diabetics will have an Annual Eye Exam (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2022 QI Work Plan).

QI21.12 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: Greater than 98.30% of Diabetics will have Nephropathy Monitoring

Goal: Met

Data/Analysis: The 2021 final rate was 100%.

Comprehensive Diabetes Care: Medical Attention for Nephropathy					
	2019 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
100%	94.19%	95.95%	97.08%	98.30%	**98.78%**

Comprehensive Diabetes Care: Nephropathy Monitoring				
	2021 Star Rating Measure Cut Points			
MY 2021 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	NA	80% to 95%	95% to 97%	**≥ 97%**

Summary Key Findings/Opportunities for Improvement: In 2021, 100% of our diabetic participants received nephropathy monitoring, matching our success from 2020. The PACE QI department works closely with the medical team in providing data generated reports identifying which participants required nephropathy screening/monitoring. These results are comparable to a 5-Star Medicare rating based on the 2021 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95th percentile. PACE will maintain this goal in 2022.

QI21.13 Decrease the rate of participant falls at Home or at the PACE day centers

Goal: <6.65 Falls per 1000 member months occurring at the PACE day centers (ACS and Garden Grove PACE)

AND

≥17% of participants will not experience a recurring fall within the same quarter at home.

Goal: Met

Data/Analysis:

The 2021 rate was 0.41 falls per 1000 member months at the PACE day center:

Quarter 2021	# Falls	Member Months	# Falls Per 1000 Members Months
Q1	0	1171	0.00
Q2	1	1191	0.84
Q3	1	1218	0.82
Q4	0	1254	0.00
EOY	**2**	**4834**	**0.41**

80% of participants did not experience a recurring fall at home within the same quarter:

Quarter 2021	Rate
Q1	71%
Q2	87%
Q3	83%
Q4	80%
EOY	**80%**

Summary Key Findings/Opportunities for Improvement:

We met our goal for day center falls during 2021. However, it should be noted that fewer participants were in the PACE Center due to the COVID-19 pandemic, and that no members attended our ACS sites. Additionally we met our goal of having less recurrent falls within the same quarter at home. We examined various elements of each fall, such as where they occurred and the contributing factors. In 2022, will be making modification s to this quality element. “Falls at Home or in the PACE Day Center” will be changed to “Fall at Home Classified as CMS reportable Quality Incidents” as this will more accurately reflect our efforts in ensuring participant safety. We feel that falls with injury are an area of special focus for prevention. Our new goal will be ≤ 207 falls with injury per 1000 participants per year.

QI21.14 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <35.73%

Goal: Met

Data/Analysis: The 2021 rate was 17%.

DDE: Dementia + Tricyclic Antidepressant or Anticholinergic Agents					
	2019 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
17%	44.44 %	40%	35.73%	33.96%	**33.96%**

Summary and Key Findings/Opportunities for Improvement:

In 2021, 17% of our participants who were diagnosed with dementia were prescribed a tricyclic antidepressant or anticholinergic agent. The PACE QI department worked closely with the medical team and generated reports of participants with dementia who were also prescribed the cautionary medications. On a monthly basis our medical providers, clinical pharmacists and data specialists, review in detail all the medications that are considered "red flags" per CMS and Beer's criteria. This is shared with other clinical medical providers and alternative medication options are discussed during provider meetings. Our clinical pharmacist is instrumental in reviewing medications ordered by providers, confirming that there are no contraindications to the drugs and then recommending alternative medication options, thereby preventing adverse outcomes. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile. Based on 2020 updates to HEDIS guidelines, in 2022 we will be changing our goal from <35.73% to <27.24 (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in 2022 QI Work Plan) and feel confident that we will once again exceed this goal.

QI21.15 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs

Goal: <3.90%

Goal: Met

Data/Analysis: The 2021 rate was 0.0%.

DDE: CKD+ Nonaspirin NSAIDS or Cox2 Selective NSAIDs				
	2019 Medicare Quality Compass			
MY 2021 PACE	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
0.0%	9.31%	6.36%	3.90%	**2.47%**

Summary and Key Findings/Opportunities for Improvement:

Careful review of participants with chronic kidney disease who are prescribed NSAIDS is an important factor in limiting the progression of kidney disease. Our in-house clinical pharmacist is a vital asset in monitoring potential drug/disease interactions and presenting therapeutic alternatives to the medical provider. The continued coordinated efforts of the PACE medical providers and the PACE clinical pharmacist will assure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile. Based on 2020 updates to HEDIS guidelines, in 2022 we will be changing our goal from <3.90% to <3.47% (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in 2022 QI Work Plan) and feel confident that we will once again exceed this goal.

QI21.16 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 90mg

Goal: 100% of participants receiving opioids for 15 or more days at an average MME 90mg will be reevaluated monthly by their treating provider.

Goal: Met

Data/Analysis: The 2021 rate was 100%

Quarter 2021	# Participants with High Dosage of Opioids
Q1	2 out of 2 participants reevaluated (100%)
Q2	2 out of 2 participants reevaluated (100%)
Q3	1 out of 1 participant reevaluated (100%)
Q4	2 out of 2 participants reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement:

In the 2021 we were able to fully meet our goal of 100% for each quarter. It should be noted that we have very few participants who exceed the established recommendations of daily morphine MME dosing. The PACE QI department generates a monthly report of participants who are prescribed higher opioid doses and this list is shared with the medical team. These specific participants are then automatically added onto the provider's monthly schedule so that appropriate participant/PCP follow-up can occur. Discussions around prescribing opioids are a recurring agenda item on weekly provider meetings, thereby enhancing provider education. We will continue to track and monitor this in 2022 and anticipate that we will again achieve 100% in 2022.

QI21.17 Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge

Goal: ≥ 90% of participants will have their medications reconciled within 30 days of hospital discharge in 2021

Goal: Met

Data/Analysis: 100% of participants had medications reconciled within 30 days post discharge in 2021.

Medication Reconciliation Post-Discharge	Q1 2021	Q2 2021	Q3 2021	Q4 2021	EOY
Total # of Discharges	41	36	46	33	**156**
Received Reconciliation	41	36	46	33	**156**
Rate	**100%**	**100%**	**100%**	**100%**	**100%**
Goal	**90%**	**90%**	**90%**	**90%**	**90%**

Medication Reconciliation Post-Discharge	
	2019 Medicare Quality Compass

MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	**90th Percentile**
100%	36.83%	46.16%	59.74%	**71.43%**

Medication Reconciliation Post-Discharge					
	2021 Star Rating Measure Cut Points				
MY 2021 PACE	1 Star	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	<48%	48% to 62%	62% to 71%	71% to 84%	**≥ 84%**

Summary and Key Findings/Opportunities for Improvement:

Medication reconciliation post hospital discharge remains one of our top priorities. In 2018, we contracted with House Calls Medical Associates which serves as our after-hours call center and provides us with our hospitalists and nursing home physicians. In 2019, the contract with House Calls Medical Associates extended to the provision of PCPs within the PACE clinic. Through this partnership, our providers maintain a close relationship with our participants and can take care of our participants across all levels of care thereby improving continuity of care. This partnership allows for prompt medication reconciliation after hospital discharge. Our clinical pharmacist also plays a vital part in the reconciliation process as well as a dedicated additional clinical staff member who handles medication reconciliation for hospital and SNF discharges. These results are comparable to a 5-Star Medicare rating based on the 2020 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95th percentile. In 2022, we plan to change the goal of Post-Discharge Medication Reconciliation from within 30 after discharge to within 15 days after discharge to better ensure that our participants post-discharge needs are met in a timely manner to prevent readmission.

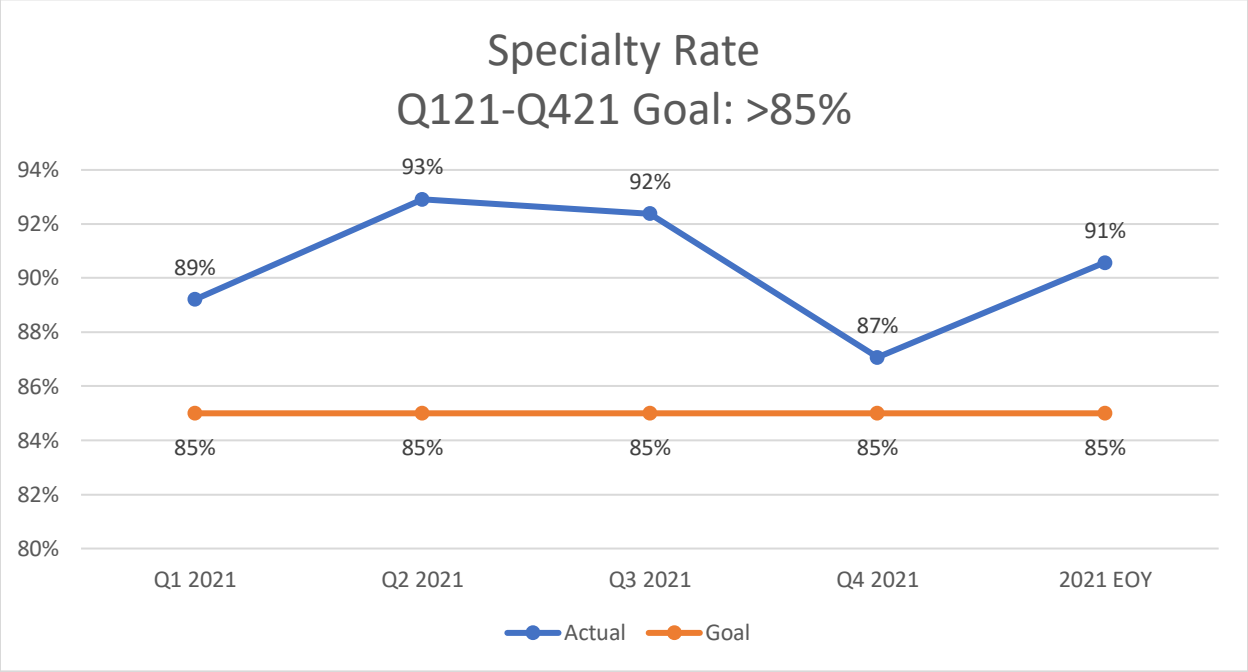
Access and Availability

QI21.18 Improve access to specialty practitioners

Goal: ≥ 85% of specialty care authorizations will be scheduled within 10 business days in 2021

Goal: Met

Data/Analysis: The 2021 rate was 91%.



Summary and Key Findings/Opportunities for Improvement:

Our PACE scheduling department continues to utilize strategies put in place to improve access to specialty care. One area of redesign was the expansion of staff dedicated to scheduling specialty appointments. This task is rather complex in that the staff member not only schedules the appointment for the participant, but also handles appointment confirmation, coordinating transportation needs, and submitting relevant medical records to the specialist. Additionally, we continue to have a scheduler who is assigned to each of our 5 IDT teams and focuses on coordinating all these activities.

We continued to provide dentistry services on-site as well as a nurse practitioner dedicated to primary care podiatry issues. We have also been able to add and on-site psychiatry services and nephrology services. This greatly enhanced specialty access, particularly for our diabetic participants. Throughout 2021 we have been able to return to some of those in house specialist activities, following COVID protocols. As part of our operational Work Plan for 2022, we will look to identify additional core specialists who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as care coordination through prompt consult notes and real-time dialogue between the specialist and the PACE medical provider. Because of the challenges we have encountered in specialty scheduling for some services, in 2022 we are changing our benchmark to ≥ 85% of specialty care authorizations will be scheduled within 14 business days.

Utilization Management

QI21.19 Increase the rate of participants who are utilizing the telehealth platform

Goal: ≥65% of participants will be able to engage in telehealth visits

Goal: Not Met

Data/Analysis: 63% of participants were able to engage in telehealth visits

Summary/Key Findings/Opportunities for Improvement

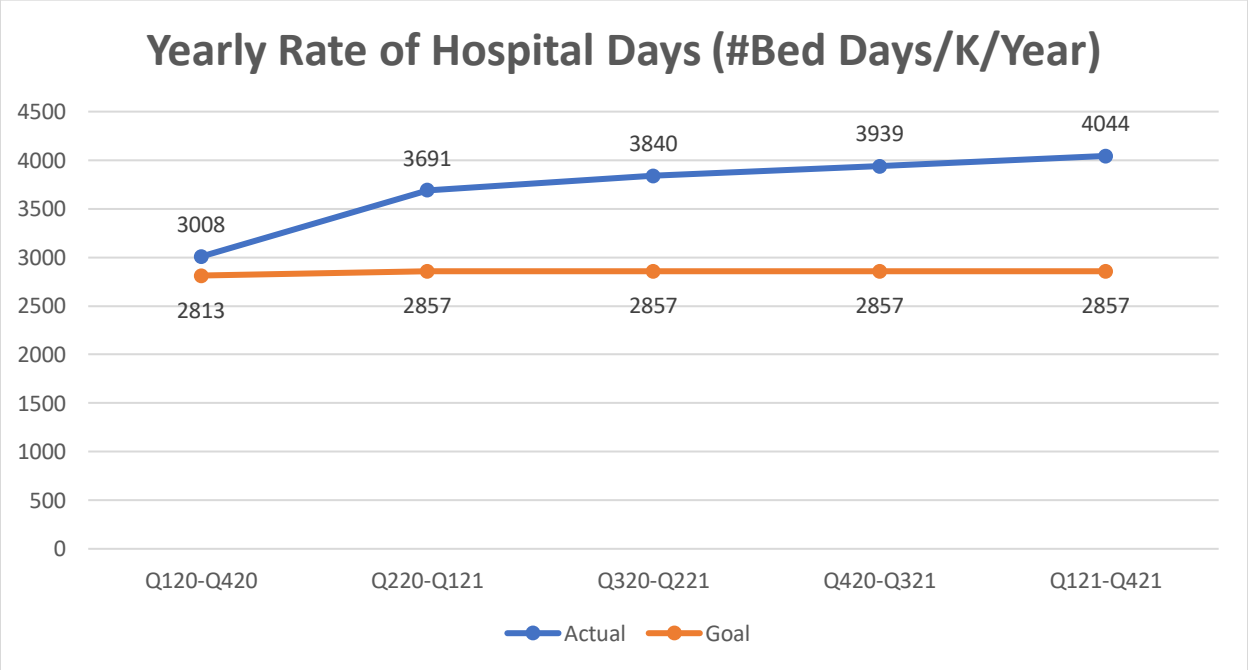
Though we came close to goal, PACE did not meet the benchmark of ≥ 65% of participants will be able to engage in telehealth visits. Telehealth access is measured by the percentage of participants who are able install and correctly use our PACE designated telehealth platform VSEE or other video conferencing applications. There are several challenges in providing video telehealth visits including a lack of accessibility to participants who may not have the devices, bandwidth or capability of using these applications. By the end of 2021, participants were being seen in person at the center again, and so the need for video conferencing lessened. Due to the many complexities involved, in 2022 we propose to return telehealth engagement to a PACE quality initiative, with a goal of increasing accessibility to ≥66%.

QI21.20 Reduce the rate of acute hospital days by PACE participants

Goal: < 2,857 hospital days per 1000 per year

Goal: Not Met

Data/Analysis: The 2021 rate was 4,044 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

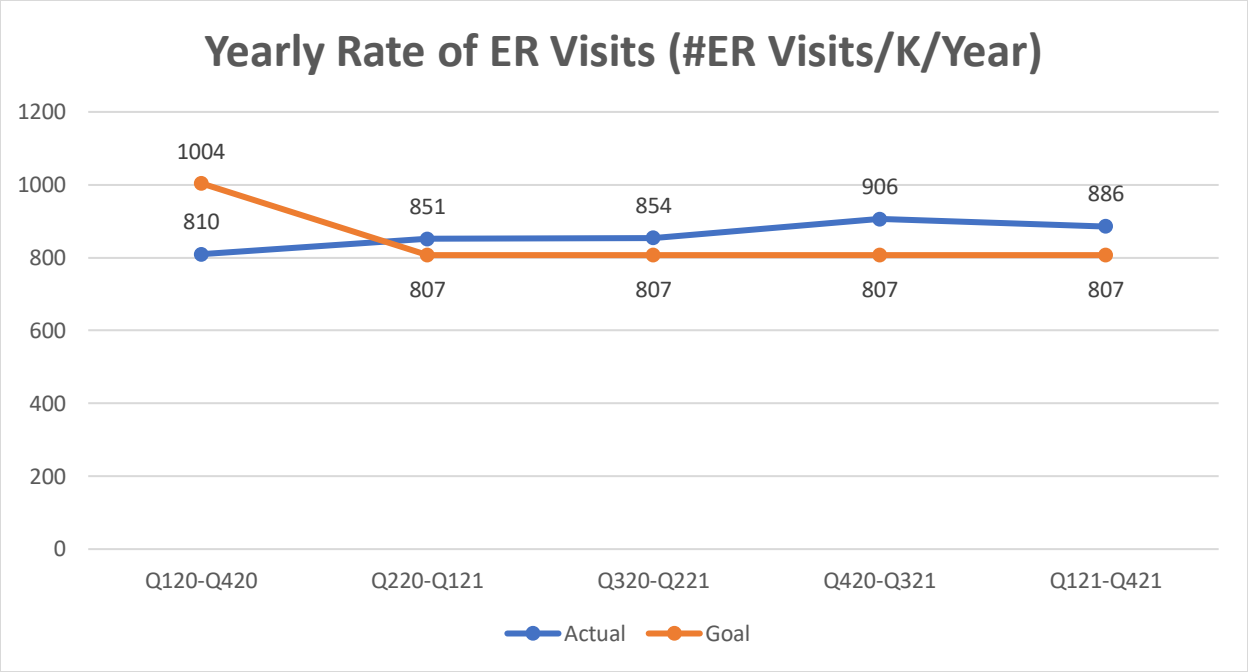
CalOptima PACE did not meet our goal of <2,857 hospital days per 1000 per year in 2021. The main reason for this is the high number of medically complex patients that are part of our program. In order to reach realistic standards for our program while continuing to strive for improvement, in 2022 we will be adjusting our goal <3,330 hospital days per 1000 per year. 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.

QI21.21 Reduce the rate of ER utilization by PACE participants

Goal: < 807 emergency room visits per 1000 per year

Goal: Not Met

Data/Analysis: The 2021 rate was 886 emergency room only visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

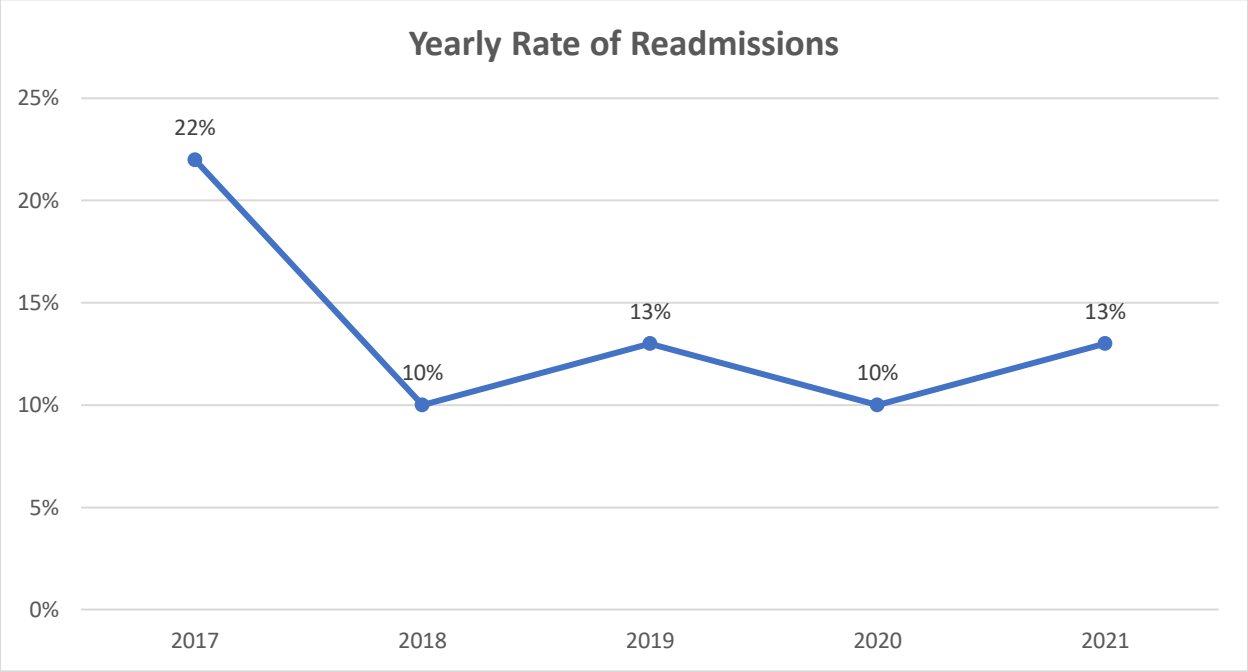
Emergency rooms visits increased throughout the year in 2021 and our of the year rate did not meet our goal. Similar to our hospital utilization rates, we will be changing this goal in 2022. The goal in 2022 will be <850 emergency room visits per 1000 per year. ER utilization by PACE participants will 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.

QI21.22 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 15% 30-day all cause readmissions

Goal: Met

Data/Analysis: The 2021 rate was 13%.



Summary and Key Findings/Opportunities for Improvement:

The readmission rates tend to have a great deal of variance year to year due to the small total number of participants and readmissions. We ended 2021 with a 13% 30-day readmission rate which is a 3% increase from 2020, but still met our benchmark. Our major challenges in readmissions are the medical complexity of our participants, non-compliance on the part of the participant and lack of family support. In 2021, we continued to incorporate the morning clinical huddles into the interdisciplinary team meetings (IDT). This concept was piloted in Q4 of 2019 with one IDT with great success and was adopted program wide in 2020. Additionally, important measures taken by PACE PCPs aided in our ability to meet our goal to reduce 30-day hospital readmissions. PCPs utilized telehealth to triage participants health needs before they required emergency services, such as following up on wellness calls as necessary and providing telemedicine services though the afterhours clinic line. PCPs also followed up with participants soon after their hospital discharge in order reassess the participants immediate health needs following hospitalization as well as any long-term need for changes in care plan to prevent future hospitalizations.

For 2022, we strive to continue our low readmission rates and change our goal from <15% to <14% readmission rate.

QI21.23 Decrease the percentage of participants who are placed in a long-term care facility

Goal: < 4% of participants will reside in long-term care (LTC)

Goal: Met

Data/Analysis: 2021 rate was 2.8% of the PACE enrollment

Summary and Key Findings/Opportunities for Improvement:

One of the most important goals of the PACE program is to help our participants continue to live safely at home for as long as possible. We ended the year with 2.8 % of our participants who resided in LTC. This is a slight increase from the 1.7% rate in 2020 but is still less than the CalPACE average of all California PACE programs of 3%. However, this is an area that we are monitoring closely as we expect we may see an increase in the upcoming years. There are several issues which is contributing to the rise in PACE LTC census for our high-risk participants, especially for those with multiple advanced chronic conditions. These are participants whose outpatient management has been unsuccessful in the home, assisted living facility (ALF) or board and care (B&C) environment. Families and caregivers may be unable or unwilling to assist with necessary care tasks at home. Poor family support and fragile living environments can lead to increased ER and hospital utilization. On some occasions, participants need temporary placement in LTC as a custodial care measure. These are participants with complex medical conditions that require complicated workups, specialty care, and who have difficulty with maintaining their care plan on their own at home. For example, participants who are noncompliant with their prescribed medications, refuse to attend their hemodialysis sessions, or have recurrent falls where all other fall prevention measures have failed. These participants benefit from placement in LTC facilities until their health is stabilized and they can be reassessed and reeducated regarding their health plan. In 2022, we plan to maintain our benchmark and investigate solutions to address the individualized care needs of our unique population.

Enrollment

QI201.24 Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment

Goal: The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%

Goal: Met

Data/Analysis: We had 1 controllable disenrollment within 90 days which was 1.3% of the total disenrollment (77 total disenrollment in 2021)

Summary and Key Findings/Opportunities for Improvement:

In 2021, we meet our goal of less than 6.5% controllable disenrollments. Our controllable disenrollment rate for 2021 was 1.3%. In the past we had participants who had disenrolled for controllable reasons with the main reason of wanting to keep their pre-enrollment PCP and/or health plan. In effort to reduce these numbers, data related to disenrollment for controllable reasons is shared with the enrollment team throughout the year. Marketing and Enrollment has made progress in this area by having developed the team infrastructure required to address this metric during the enrollment process and by collaborating with both Operations and Clinic on participant issues that may arise up to 3 months after a participant's program capitation date. In 2021, we saw that those efforts worked well, and we fell within our benchmark. Now that we have an established method for making sure all participants are aware of what PACE offers, we have decided that this no longer needs to be a quality element and will instead continue to be an operational issue. We will remove this element in 2022.

QI21.25 Increase the Qualified Lead to Enrollment conversion rate

Goal: Increase the Qualified Lead to Enrollment conversion rate to 60%

Goal: Met

Data/Analysis: Final rate was 79%.

Quarter 2021	Rate
Q1	88%
Q2	88%
Q3	72%
Q4	74%
EOY	**79%**

Summary and Key Findings/Opportunities for Improvement:

In 2021, we exceeded our goal in the percentage of qualified leads to enrollment. This afforded the frail and elderly in our community greater access to health care in an environment which also supports their physical, rehabilitative, and psychosocial needs.

Several strategies led to successful enrollment:

1. Revision of our screening, intake, and assessment tools to screen-out enrollees including those who were too high-functioning and would not be eligible per State certification, although they initiated an inquiry.
2. Utilization of data indicating origins of referrals to PACE.
3. Redesigned marketing collateral which educated the community in the benefits of enrolling in PACE.

In 2022 we will continue to review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies to maintain our current benchmark of >60%

Transportation

QI21.26 and QI201.27: Transportation

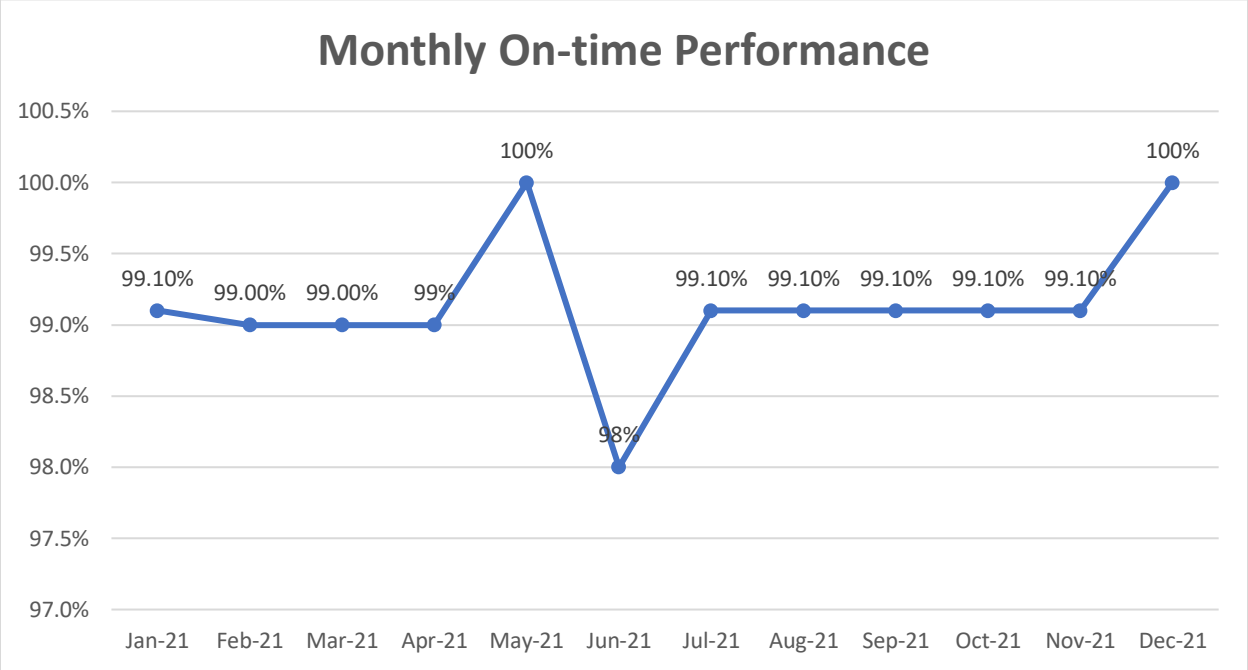
Goal: Ensure PACE transportation ride times are less than 60 minutes per trip with a g 0 trips > 60 minutes in duration and improve participant experience by providing timely transportation services with a goal of ≥ 92% on-time performance.

Goal: Met

More than 60 minutes in ride duration: 0 trips
On-time performance: ≥ 92%

Data/Analysis: 2021 data

More than 60 minutes in ride duration: 0 trips
On-time performance: 99%



Summary and Key Findings/Opportunities for Improvement:

2021 was a transitional time for the transportation department. Due to the pandemic, as with 2020 the transportation department was utilized for drive-through immunization and COVID-19 testing, delivery of care packages and durable medical equipment. In Q3 of 2021 we reopened day center services for selected participants on a limited basis. Despite the increased demands and ever-changing protocols, the transportation has continued to meet their benchmark. For the year, transportation completed 30,696 one-way trips with an on-time performance of 99%. We will continue to actively monitor trends in transportation, not just in terms of on-time-performance, but also for participant satisfaction.

Meals

QI21.28 Improve the overall satisfaction of participants with meals within the PACE program

Goal: ≥ 71% on Satisfaction with Meals summary score on the 2021 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 80% overall weighted participant satisfaction summary score.

2021 Participant Survey Satisfaction with Meals Domains

Domain	2020	2021	2021 National Average
Do the lunches look good?	81%	88%	69.6%
Do the lunches taste good?	75%	75%	61.6%
Do you get a variety of foods here?	78%	80%	81.7%
Meal satisfaction composite score	78%	**80%**	70.8%
Overall, would you rate the lunches as excellent, very good and/or good?	80%	84%	79.2%

Summary and Key Findings/Opportunities for Improvement:

In 2021, we met our benchmark with 80% of PACE participants indicating satisfaction with their meals, exceeding the PACE national average of 70.8%. In 2021, we engaged the services of a research entity which surveyed participant satisfaction for PACE programs statewide. One of the domains surveyed was a participant's satisfaction with meals. Survey responses indicated that participants were generally satisfied with meals provided by PACE. In 2021, we made an active effort to present a variety of meals which were not only nutritious, but also consistent with the cultural background of our participants. For 2021-40,268 meals were delivered to PACE participants in their homes.

Most participants indicated that the meals looked appealing, tasted good and were varied. Our dietary team monitored participant meals, frequently adjusting menus to be consistent with therapeutic diet parameters as well as an individual's preference. We will continue to monitor this domain in 2022.

Overall Satisfaction

QI21.29 Improve the overall satisfaction of participants and their families with the CalOptima PACE program

Goal: Greater than or equal to 88% on the Overall Satisfaction Weighted Average on the 2021 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: 91% overall weighted participant satisfaction summary score.

Participant Survey Overall Satisfaction Domains

Domain	2020	2021	2021 National Average
Would you recommend the program to a close friend or relative?	91%	94%	92.3%
Overall satisfaction with the care received	88%	96%	94.8%

2021 Participant Survey Domains

Domain	2020	2021	2021 National Averages
Transportation	95%	96%	93.6%
Center Aids	96%	95%	91.2%
Home Care	90%	90%	86.2%
Medical Care	91%	93%	90.1%
Health Care Specialist	87%	88%	89.1%
Social Worker	93%	97%	94.5%
Meals	78%	80%	70.8%
Rehabilitation Therapy and Exercise	87%	91%	93.1%
Recreational Therapy	85%	85%	79.0%
General Service Delivery	N/A	92%	86.9%
Weighted Summary Score	89%	**91%**	88.5%

Summary and Key Findings/Opportunities for Improvement:

In fall 2021, CalOptima PACE contracted with Vital Research to conduct the Participant Satisfaction Survey. Vital Research interviewed 112 participants via telephone, to gauge the participant's satisfaction with CalOptima PACE services. This is a standardized survey taken by most of the PACE programs in the country.

The overall satisfaction score was 91%. High marks were given to our center aides, transportation, medical team, home care, and social work departments. Overall, our scores increased in all but one area from 2020 to 2021 and we exceeded national averages on most domains. 94% of our participants indicating they would recommend PACE to a close friend or relative in need of this kind of care. In 2022 we hope to reopen the day center to full capacity and once again be able to provide our comprehensive therapy and exercise programs to all participants to improve satisfaction in that area.

SECTION 5: 2020 HEALTH PLAN MANAGEMENT SYSTEM (HPMS)

2021 HPMS: In 2018, 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
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

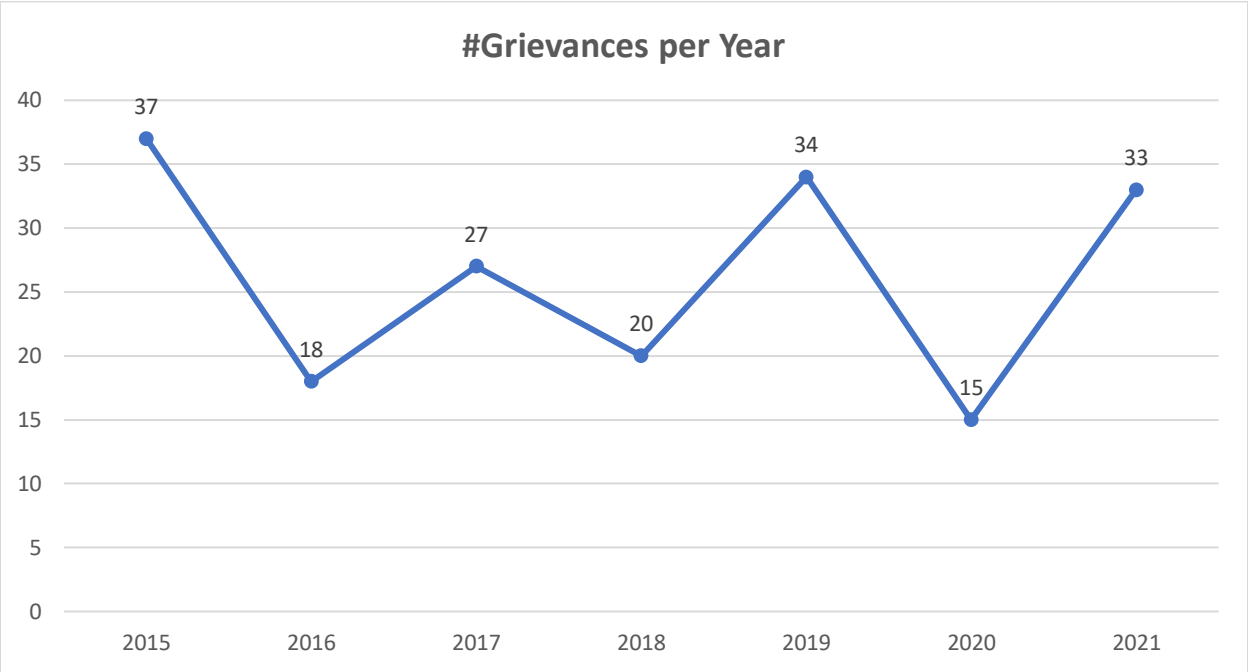
Grievances

Data Analysis:

Quarterly Grievances Q1 2021–Q4 2021

	CENTER							CLINIC			
					Transportation			Clinical Care/Service/ Treatment			
	# Grievances	Other	Food	Home Care	Timeliness	Prt-Driver Interaction	Escort	Dissatisfaction	Timeliness	Comm-unication about care	Scheduling/ Communication
Q1 2021	4	0	0	0	2	1	0	1	0	0	0
Q2 2021	10	0	0	0	5	0	0	2	0	3	0
Q3 2021	7	1	0	0	4	0	0	1	0	0	1
Q4 2021	12	1	0	0	7	0	0	3	0	1	0

Grievances Per Year 2015–2021



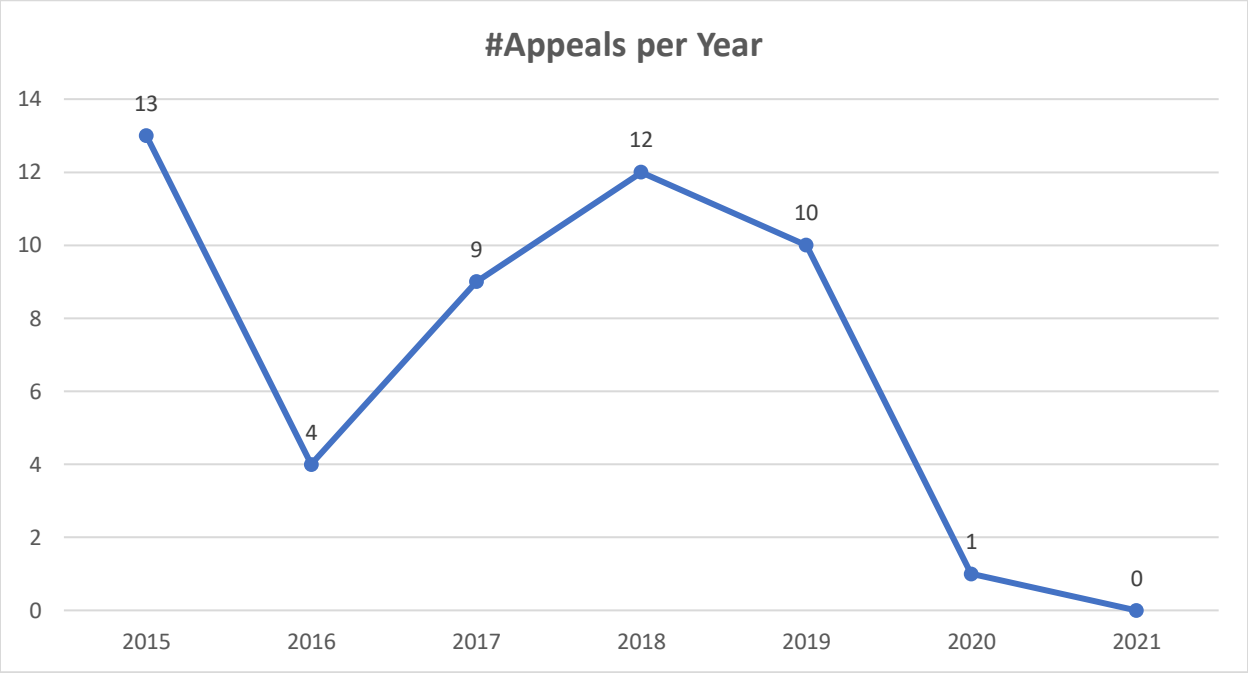
In 2021, we saw an increase in the number of grievances filed by participants. Many of the grievances were transportation related issues such as being picked up late. Despite this, our participant satisfaction survey revealed that 96% of participants were satisfied with transportation services. All grievances are investigated by our QI department and a resolution to the grievance is provided to the participant within a 30-day period.

The majority of participants filing grievances are satisfied with the resolutions reached by the PACE QI department. As with previous years, we will continue to monitor and observe for trends with grievances filed.

Appeals

Data Analysis:

Appeals Per Year 2015–2021

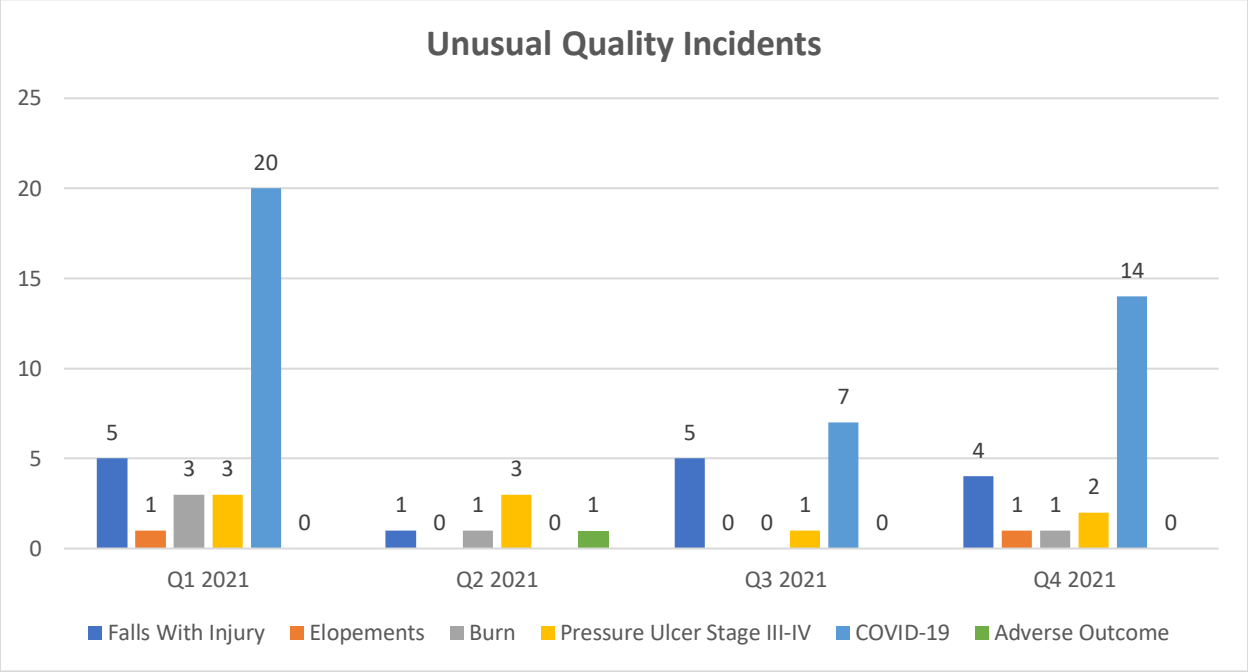


No appeals were submitted in 2021. This is likely due to processes in place for PACE team to explain the reasons for request denials to our participants and ensure that reasons for denials are thoroughly elucidated.

Level II Events/Unusual Quality Incidents

Description of Level II Events: Unusual quality incidents (formerly referred to as Level II events) are monitored by the PACE QI team. Unusual quality events including falls with injury, elopements, burns, pressure ulcers (stage III–IV) and infectious disease outbreaks and are reported to CMS and DHCS on a quarterly basis. Essentially, the objective is to monitor the health and safety of PACE participants as well as the effectiveness of our risk management and QI program. All unusual quality incidents are reported to the QI team with an ensuing root cause analysis (RCA) completed on each incident. The RCA begins with the QI team investigating the incident (what, where and when) then followed by a meeting of appropriate disciplines such as nursing, social worker, rehabilitation services. Potential causes of the incident are discussed and interventions to prevent further occurrences are implemented. In some instances, interventions could include systemic or operational failures which need remediation. In 2021, there was only one quality incident that required an operational change (transportation team completed a corrective action plan regarding a reported elopement).

Data Analysis: See graph below



Falls with injury are usually one of the most prevalent unusual quality event at PACE. As the stay-at-home orders were mandated, participants sustained more falls in their home. The number of falls however did not increase significantly from 2020. As with the previous year, the majority of falls are either a result of non-use of durable medical equipment or lack of family supervision. In 2021, due to the ongoing COVID-19 pandemic, we saw an increase in reporting of infectious disease cases under unusual quality incidents, especially in Quarter 1 (before availability of widespread COVID-19 vaccination) and in Quarter 4 (worldwide COVID-19 Omicron variant surge).

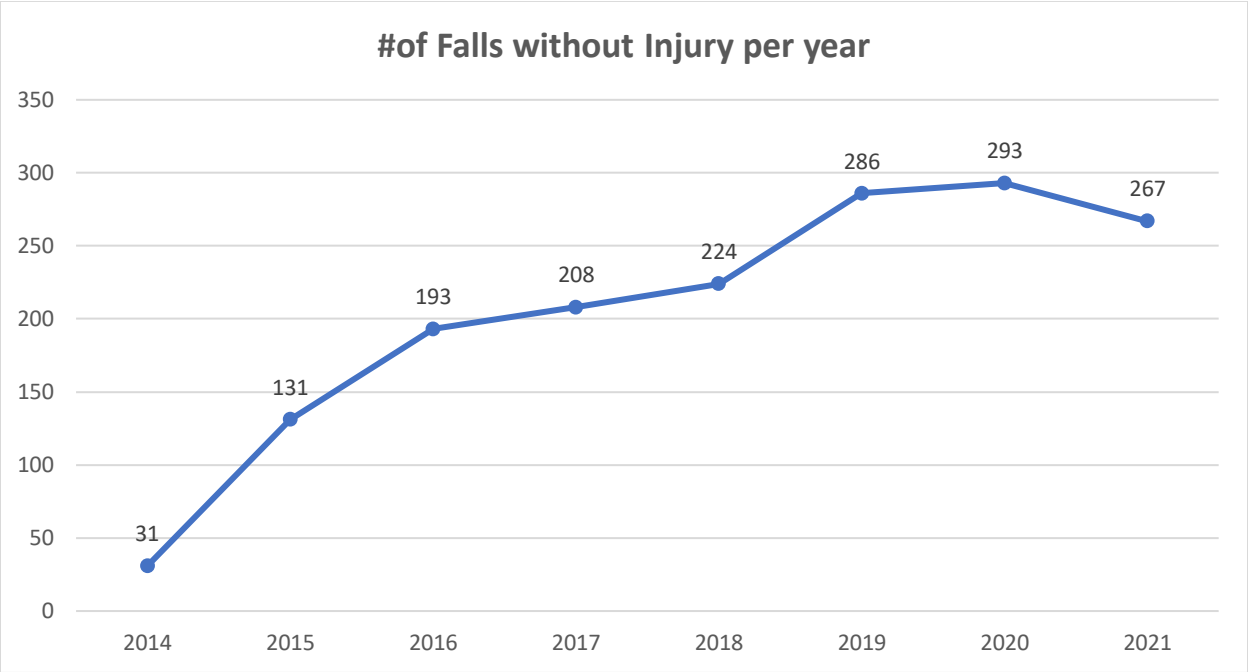
Medication Errors

A total of 2 medication (dosage) errors were reported in 2021. One of the medication errors was attributable to PACE clinic staff error. In response to the staff error, education and training were implemented. Another dosage error was made by a contracted home health nurse. In this case, we requested a corrective action plan from the home health agency and they complied with this request. No further incidents have occurred.

Falls Without Injury

Data Analysis**:**

Falls without Injury 2014–2021



As in previous years, we have continued to maintain a relatively low number of falls. In 2021, we saw a decrease from 2020 figures. 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 of continued decreasing fall trends. The "PACE Fall Prevention" group is comprised of PACE participants who are educated by the rehabilitation staff in fall recovery mechanisms.

Other groups PACE created to reduce falls include:

1. *Fallers Anonymous*: Comprised of PACE participants who meet quarterly with the rehabilitation team to discuss safety in the home and environment.
2. *Matter of Balance*: Targets those participants with cognitive impairment. Discusses the many misconceptions surrounding falls.

These groups were put on hold d/t current closure and restrictions in the center- they will both resume once PACE returns to normal scheduling.

Disciplines, including physicians, nurses, social workers, physical and occupational therapy, and clinical pharmacy, collaborate to develop participant-specific strategies for fall prevention. PACE is using an individualized approach to falls. Once any of the disciplines get information from participants and/or families via wellness calls related to a fall, they will send a Clinic Service Request to clinic and rehab for quick intervention. Rehab then reaches out to participant/family to provide immediately education and follow-up. If further evaluation and skilled rehab is warranted, PACE will ask the participant to do an in-person visit at PACE center. In this way, PACE maintains a direct response to each and every fall reported in a timely manner.

Denials of Prospective Enrollees

In 2021, one prospective enrollee w**as** denied enrollment by the State. This prospective enrollee's health and safety would be jeopardized by living in a community setting.

Quality Initiatives

In 2021, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes related to the COVID-19 pandemic. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's two quality initiatives in 2021 were in response to the COVID-19 pandemic.

- COVID-19 Vaccine Quality Initiative.
  - This initiative focused on vaccine education, outreach, and vaccine distribution coordination.
- Telehealth Engagement Quality Initiative
  - This initiative focused on accelerating the adoption and utilization of telehealth by the PACE participants. It involved education, training and ensuring our participants have the hardware to utilize our telehealth services.

SECTION 5: OPPORTUNITIES FOR IMPROVEMENT IN 2022

1. **Improve the Quality of Care (QOC) for Participants**
   a. Addition of new COVID-19 booster immunization quality initiative to ensure all participants get vaccinated.
   b. Continue to expand telehealth services, drive through clinics and home visits.
   c. Refine clinical triage workflow.
2. **Ensure the Safety of Clinical Care**
   a. The QI team will continue to focus on strengthening oversight activities of external providers and vendors specifically related to home care, skilled nursing facilities, board and care facilities and transportation.
   b. The grievances and potential quality issues involving downstream vendors will continue to be tracked and trended to assure no service or clinical trend is emerges.
   c. Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.
3. **Ensure the Appropriate Use of Resources**
   a. Inpatient/ER Utilization
      i. Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants.
      ii. Continue to refine the ER Diversion program.
   b. Specialty Care

i. Increase the number of core PACE specialists who are willing to work closely with the PACE program, receive training in the PACE Model of Care.
ii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.

c. Staffing
i. Continue refinement of the staff relative value units (RVUs) to monitor staff productivity.

4. **Improve Participant Experience**
a. Participants will be updated on the satisfaction survey process.
b. Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement.
c. Once participants return to the PACE day center at full capacity, we will restart the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.

5. **Ensure Appropriate Access and Availability**
a. Reopening of access to ACS sites will continue to be considered in 2022 based on appropriate COVID-19 guidelines.
b. Continued development of our list of preferred specialists who are willing to work closely with PACE, be trained in the PACE model of care and attend occasional interdisciplinary care team meetings.
c. Will continue to bring specialists in to provide specialty care within the PACE clinic.

SUMMARY

CalOptima PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to live safely in our community with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, care management and disease management, closing any potential gaps in care. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and participant satisfaction. 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, we are confident that our QI efforts will continue to make a positive impact amongst our participants.

APPENDIX: 2021 PACE QI EVALUATION

2021 CalOptima PACE Quality Improvement (QI) Work Plan																	
QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.01	Improve the Quality of Care for Participants	2020 PACE QAPI Plan and Work Plan Annual Evaluation	2020 PACE QAPI Plan will be evaluated by March 1st, 2021	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2021	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met	Met
QI21.02	Improve the Quality of Care for Participants	2021 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2021	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2021	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met	Met
QI21.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2021	Improve compliance with influenza immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Q3 and Q4 2021	12/31/2021	PACE Clinical Operations Manager	N/A	N/A	N/A	N/A	10%	Not Met	91%	Not Met	91%	Not Met
QI21.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2021	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Quarterly	12/31/2021	PACE Clinical Operations Manager	83%	Not Met	93%	Not Met	96%	Met	94%	Met	94%	Met
QI21.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥80% of eligible participants will have had their COVID-19 vaccination by December 31st, 2021	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Quarterly	12/31/2021	PACE Clinical Operations Manager	86%	Met	93%	Met	96%	Met	95%	Met	95%	Met
QI21.06	Improve the Quality of Care for Participants	Infection Control	In 2021, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	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	12/31/2021	PACE Clinical Operations Manager	0.8	Met	0.08	Met	0.41	Met	0.61	Met	0.48	Met
QI21.07	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2021	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	12/31/2021	PACE Center Manager	89%	Not Met	90%	Not Met	94%	Not Met	93%	Not Met	91%	Not Met
QI21.08	Improve the Quality of Care for Participants	Advanced Care Planning: Advance Health Care Directive	≥40% of participants will have an Advanced Health Care Directive in place by December 31st, 2021	Ensure all PACE members are offered assistance with the completion of the Advance Health Care Directive	Quarterly	12/31/2021	PACE Center Manager	41%	Met	44%	Met	44%	Met	42%	Met	43%	Met
QI21.09	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	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months. Exclusion: Participants in unstable condition due to a hospitalization. Assessment to be	Quarterly	12/31/2021	PACE Center Manager	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.10	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2021	PACE Clinical Medical Director	83%	Met	84%	Met	84%	Met	89%	Met	89%	Met
QI21.11	Improve the Quality of Care for Participants	Diabetes Care	>85.33% of Diabetics will have an Annual Eye Exam (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2021	PACE Clinical Medical Director	99%	Met	100%	Met	100%	Met	95%	Met	95%	Met

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.12	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2021	PACE Clinical Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.13	Ensure the Safety of Clinical Care	Falls at Home or in the PACE Day Center	<6.65 Falls per 1000 member months) occurring at the PACE day centers (ACS and Garden Grove PACE) ≥17% of participants will not experience a recurring fall within the same quarter	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. Falls occurring in the home or community will be monitored by the PACE QI department who will work	Quarterly	12/31/2021	PACE Center Manager	0 71%	Met	0.84 87%	Met	0.82 83%	Met	0 80%	Met	0.41 80%	Met
QI21.14	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<35.73% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2021	PACE Clinical Medical Director	16%	Met	17%	Met	18%	Met	17%	Met	17%	Met
QI21.15	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	<3.90% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2021	PACE Clinical Medical Director	0%	Met	0.0%	Met	0.0%	Met	0.0%	Met	0.0%	Met
QI21.16	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 of 90 MME/day will be reevaluated monthly by their treating provider in 2021.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2021	PACE Clinical Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.17	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 2021	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2021	PACE Pharmacist	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.18	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥85% of specialty care authorizations will be scheduled within 10 business days in 2021 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 10 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2021	PACE Clinical Operations Manager	89%	Met	93%	Met	92%	Met	87%	Met	91%	Met
QI21.19	Ensure Appropriate Access and Availability	Improve Access to PACE Care: Increase Telehealth Engagement	≥65% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2021	Community-Based Program Manager	65%	Met	66%	Met	64%	Not Met	59%	Not Met	63%	Not Met
QI21.20	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<2,857 hospital days per 1000 per year (5% decrease from 2020)	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	12/31/2021	PACE Clinical Director	3691	Not Met	3840	Not Met	3939	Not Met	4044	Not Met	4044	Not Met

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.21	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<807 emergency room visits per 1000 per year (maintain improvements made in 2020)	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	12/31/2021	PACE Clinical Director	851	Not Met	854	Not Met	906	Not Met	886	Not Met	886	Not Met
QI21.22	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<15% 30-day all cause readmission	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	12/31/2021	PACE Clinical Director	16%	Not Met	14%	Met	13%	Met	9%	Met	13%	Met
QI21.23	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	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	12/31/2021	PACE Center Manager	2.6%	Met	3.5%	Met	2.9%	Met	2.1%	Met	2.8%	Met
QI21.24	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2021	PACE Marketing and Enrollment Manager	0%	Met	0%	Met	7.7%	Not Met	0%	Met	1.3%	Met
QI21.25	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 60%) in 2021	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2021	PACE Marketing and Enrollment Manager	88%	Met	88%	Met	72%	Met	74%	Met	79%	Met
QI21.26	Improve Participant Experience	Transportation	I00% of transportation trips will be less than 60 minutes in 2021	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	12/31/2021	PACE Center Manager	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.27	Improve Participant Experience	Transportation	≥92% of all transportation rides will be on-time in 2021	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2021	PACE Center Manager	99%	Met	100%	Met	99.1%	Met	99.40%	Met	99.13%	Met
QI21.28	Improve Participant Experience	Increase Participant Satisfaction with Meals	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2021 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2021	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%	Met
QI21.29	Improve Participant Experience	Increase Overall Participant Satisfaction	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2021 PACE Satisfaction Survey	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	12/31/2021	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	91%	Met

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CALOPTIMA PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
QUALITY IMPROVEMENT PLAN DESCRIPTION

202210

PACE Quality Improvement Subcommittee Chairperson:

David RamirezEmily Fonda, M.D. Richard Helmer Miles Masatsugu, M.D. Date
Medical Director, PACEInterim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

Trieu TranMary Giammona, M.D.Paul Yost, M.D.
Date

Board of Directors Chairperson:

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~~Paul Yost, M.D.~~Andrew Do
Supervisor, First District

Date

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima PACE. It is designed and organized to support the mission, ~~values~~values, and goals of PACE.

Overview

- The goal of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking ~~them~~them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QI 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 the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix ~~B)~~A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
    - Ensure the QI program involves all providers of care within the PACE program.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
    - 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~~to identify areas needing 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 90% for the appropriate participant population.~~
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
    - Share results of QI identified benchmarks 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 staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).

- Ensure that all levels of care are consistent with professionally recognized standards of practice.
- Assure compliance with regulatory requirements of all responsible agencies.

- **Improve the participant 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 (e.g., menu selection and PMAC).
  - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
  - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration
  - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advanced Health Care Directives which honors members' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
  - Review and analyze utilization data regularly, including hospital admissions, ~~hospital readmissions,~~ Emergency Room (ER) 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 investigate any potential infractions in the quality of care provided in these settings.~~perform site visits on an ongoing basis.~~
  - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
  - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
  - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care**
  - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
  - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
  - 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.
  - Monitor and track falls occurring in the PACE Day Center and in the home and within the community.
  - Monitor and track the use of opioids at high dosages.
  - Meet or exceed community standards for credentialing of licensed providers.
  - Monitor staff and contractors to ensure that appropriate standards of care are met.
- **Ensure appropriate access and availability.**
  - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
  - Monitor and analyze access to specialty care
  - Continue to develop the network of Alternate Care Setting (ACS) 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

CalOptima Board of Directors provides oversight and direction to CalOptima PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima — including the CalOptima PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima's 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 QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI ~~Plan~~Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI 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~~to address quality problems in any clinical or administrative process that have been identified as critical to participants, families or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, Manager of Community-Based Programs, and PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues 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.

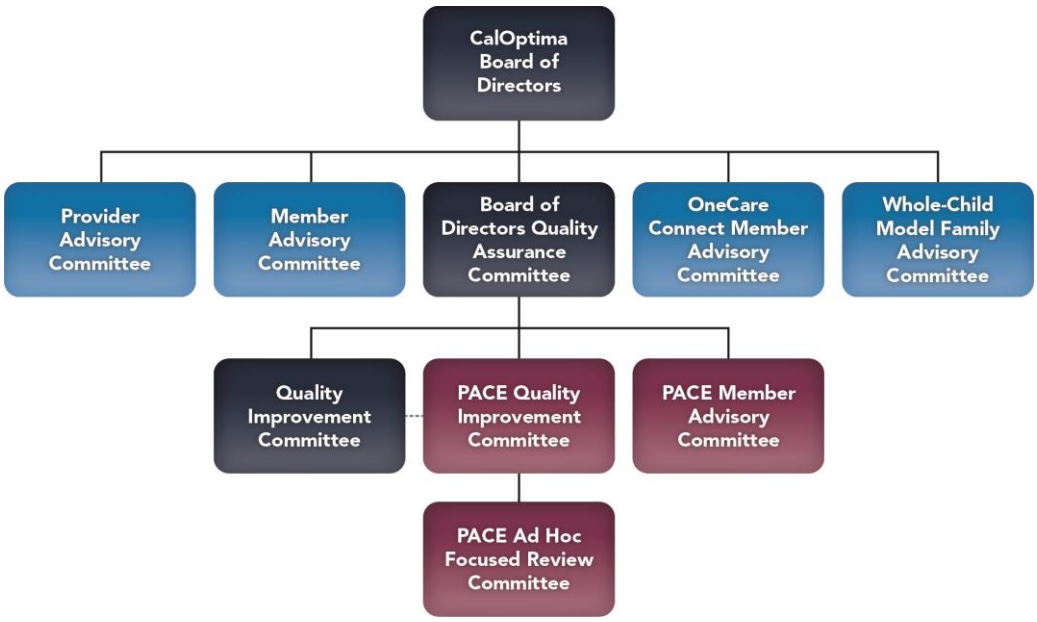
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Manager or PACE QI 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.

PACE Member Advisory Committee

Purpose
PMAC provides recommendations~~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 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. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and all interested participants are invited to join. 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 chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2022 ~~10~~ Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, ~~analyze~~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 underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback ~~in order to~~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 PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.

- PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days for controllable reasons.
- The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.

Clinically Relevant HPMS Data

- Unusual Incidents
-
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
    - Influenza Immunizations Rates ~~and~~
    - Pneumococcal Immunizations Rates ~~(mandated by CMS)~~
        - Exclusion criteria: ~~:~~
            - Participants who enrolled in the program in December 2021
    - COVID-19 Immunization Rates
        - Exclusion criteria:
            - ~~o~~ Participants who enrolled in the program in December 2022~~1~~
    - Infection Control: Respiratory Infection Rates
    - Advanced Health Care Planning: POLST Completion
    - ~~o~~ Advance Health Care Planning: Advanced Health Care ~~Healthcare~~ Directive Completion
    - ~~o Functional Status Assessment Completion~~

~~o Day Center Fall Rates~~Day Center Falls and falls occurring in the participant home or ~~within the community~~

    - ~~Opioids at High Dosage Monitoring~~
    - ~~o Medication Reconciliation Post Discharge~~
    - Diabetes Care: Annual Eye Exams
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during measurement year
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2021~~0~~
    - Diabetes Care: Nephropathy Monitoring and Blood Pressure Control
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during 2021~~0~~
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2021~~0~~
                - Participants with End Stage Renal Disease
    - Monitoring of treatment for Participants with Osteoporosis

- Falls at Home Classified as CMS Reportable Quality Incidents
- Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
  - The following inclusion and exclusion criteria will be in place for this measure:
    - Inclusion criteria:
      - Continuous enrollment throughout year
      - Participants who are 66 years and older as of December 31, 2021~~0~~
    - Exclusion criteria:
      - Participants who are end of life (less than six months)
      - Participants with Schizophrenia or Bipolar Disorder
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDs
  - The following inclusion and exclusion criteria will be in place for this measure:
    - Inclusion criteria:
      - Continuous enrollment throughout year
      - Participants who are 66 years and older as of December 31, 2021~~0~~
    - Exclusion criteria:
      - Participants who are end of life (less than six months)
- Opioids at High Dosage Monitoring
- ~~-~~Medication Reconciliation Post Discharge
-
- Access to Specialty Care

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.
- Annual competency evaluations of PACE staff.
- PACE staff will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE ~~staff~~staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight to all activities offered by PACE.
- Member grievances will be forwarded to the PACE QI Department~~QI Coordinator and QI~~

~~Manager~~ for investigation, tracking, ~~trending~~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 the results of the investigations, 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 appeals will be forwarded to the PACE QI ~~Deparment~~Department~~QI Coordinator and QI Manager~~ for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be 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 IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.

-

Continued

- i~~I~~ntegration of telehealth to expand access to care through the COVID-19 pandemic and beyond.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will monitor transportation services with perio~~d~~tic ride alongs. The times gathered during the ride alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through ~~periodic~~ participant ~~meal~~ satisfaction surveys as well as comments solicited by the PMAC.

-

- ~~Meal quality will be monitored through periodicregular participant meal satisfaction surveys as well as comments solicited by the 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.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- 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

- 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~~caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high ~~volume~~volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and SAA to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events), 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 HPMS. The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
    - 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 injuries acquired while enrolled in PACE.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
    - E~~Any e~~lopement by cognitively impaired participant ~~.~~
    - Adverse drug reactions
    - Foodborne outbreak
    - Burns 2nd degree or higher
    - COVID-19 infections
- HOS-M
    - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting 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) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant 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-Evaluation and 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.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, ~~strategies~~strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's three~~two~~ quality initiatives in 2022~~1~~ are~~: in response to the COVID-19 pandemic.~~

    ~~Two quality initiatives will be added in 2021.~~
    - COVID-19 Booster Vaccine Quality Initiative.
        - This initiative will focus on vaccine education, outreach, and vaccine distribution coordination with a goal of getting at least 8~~9~~0% of eligible

participants their COVID-19 booster~~vaccinated~~ by the end of December 2022. ~~March 2021.~~

- Telehealth Engagement Quality Initiative
  - This initiative will focus on accelerating the adoption and utilization of telehealth by the PACE participants. ~~-~~It will involve education, training and ensuring our participants have the hardware to utilize our telehealth services. The PACE Community Based Services Program Manager will implement a plan to increase prt telehealth access. The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.
- Advance Health Care Directive
  - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2022.

- ~~In 2020, a new advanced health care directive quality initiative will be added.~~

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI 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 QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

~~2021~~2022 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI21.01~~ QI22.01	Improve the Quality of Care for Participants	2021 PACE QAPI Plan and Work Plan Annual Evaluation	2021 PACE QAPI Plan will be evaluated by March 1st, 2022	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2022	PACE Medical Director
~~QI21.02~~ QI22.02	Improve the Quality of Care for Participants	2022 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2022	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2022	PACE Medical Director
~~QI21.03~~ QI22.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2022	Improve compliance with influenza immunization recommendations ~~(Exclusion: Participants who enroll in the PACE program in December 2022)~~	Q1, Q3 and Q4 2022	12/31/2022	PACE Clinical Operations Manager
~~QI21.04~~ QI22.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2022	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager
~~QI21.05~~ QI22.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥~~80~~95% of eligible participants will have had their COVID-19 vaccination by December 31st, 2022	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager
~~QI21.06~~	~~Improve the Quality of Care for Participants~~	~~Infection Control~~	~~In 2021, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days~~	~~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~~	~~12/31/2021~~	~~PACE Clinical Operations Manager~~
~~QI21.07~~ QI22.06	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2022	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	12/31/2022	~~PACE Center Manager~~ PACE Clinical Operations Manager and Clinical Medical Director
~~QI21.08~~	~~Improve the Quality of Care for Participants~~	~~Advanced Care Planning: Advance Health Care Directive.~~ Move to Quality Initiative	~~≥40% of participants will have an Advanced Health Care Directive in place by December 31st, 2021~~	~~Ensure all PACE members are offered assistance with the completion of the Advance Health Care Directive~~	~~Quarterly~~	~~12/31/2021~~	~~PACE Center Manager~~
~~QI21.09~~	~~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~~	~~Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months. Exclusion: Participants in unstable condition due to a hospitalization. Assessment to be completed upon participant discharge.~~	~~Quarterly~~	~~12/31/2021~~	~~PACE Center Manager~~

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI21.10~~ QI22.07	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
~~QI21.11~~ QI22.08	Improve the Quality of Care for Participants	Diabetes Care	~~>85.33%~~ 82.77% of Diabetics will have an Annual Eye Exam (Comparable to the ~~2019~~ 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
~~QI21.12~~ QI22.09	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the ~~2019~~ 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
QI22.10	Improve the Quality of Care for Participants	Osteoporosis (New Element)	>= 90% of participants with the diagnosis of Osteporosis will have treatment by PCP	PACE participants with diagnosis of osteoporosis witll be managed by their PCP using appropriate therapy resulting in a decrease risk of fracture.	Quarterly	01/01/2022	PACE Clinical Medical Director
~~QI21.13~~ QI22.11	Ensure the Safety of Clinical Care	~~Falls at Home or in the PACE Day Center~~ Falls at Home Clasified as CMS Reportable Quality Incidents	~~<6.65 Falls per 1000 member months) occurring at the PACE day centers (ACS and Garden Grove PACE) ≥80% of participants will not experience a recurring fall within the same quarter (At Home Only)~~ <= 207 Falls per 1000 per year	~~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. Falls occurring in the home or community 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.~~ Falls with Injury will be mornitored by PACE QI department who will work with the interdisciplinary teams and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Center Manager
~~QI21.14~~ QI22.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	~~<35.73%~~ 27.24% (Comparable to the ~~2019~~ 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
~~QI21.15~~ QI22.13	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	~~<3.90%~~ 3.47% (Comparable to the ~~2019~~ 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI21.16~~ QI22.14	**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 of 90 MME/day will be reevaluated monthly by their treating provider in 2022.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2022	PACE Clinical Medical Director
~~QI21.17~~ QI22.15	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	≥90% of participants will have their medications reconciled within ~~30~~ 15 days of hospital discharge in 2022	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2022	PACE Pharmacist and PACE Clinical Medical Director
~~QI21.18~~ QI22.16	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	≥85% of specialty care authorizations will be scheduled within ~~10~~ 14 business days in 2022 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within ~~10~~ 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2022	PACE Clinical Operations Manager
~~QI21.19~~ QI22.17	**Ensure Appropriate Access and Availability**	**Improve Access to PACE Care: Increase Telehealth Engagement**	≥~~65~~ 66% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2022	Community-Based Program Manager
~~QI21.21~~ QI22.18	**Ensure Appropriate Use of Resources**	**Reduce Acute Hospital Day Utilization**	<~~2957~~ 3,330 hospital days per 1000 per year	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	12/31/2022	PACE Clinical Director
~~QI21.22~~ QI22.19	**Ensure Appropriate Use of Resources**	**Reduce Emergency Room Utilization**	<~~807~~ 850 emergency room visits per 1000 per year	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	12/31/2022	PACE Clinical Director
~~QI21.23~~ QI22.20	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<~~15~~ 14% 30-day all cause readmission	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	12/31/202	PACE Clinical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI21.24 QI22.21~~	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	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	12/31/2022	PACE Center Manager
~~QI22.25~~	~~Improve Participant Experience~~	~~Enrollment/Disenrollment~~	~~The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%~~	~~Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement~~	~~Quarterly~~	~~12/31/2022~~	~~PACE Marketing and Enrollment Manager~~
~~QI21.26 QI22.22~~	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 60% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2022	PACE Marketing and Enrollment Manager
~~QI21.27 QI22.23~~	Improve Participant Experience	Transportation	I00% of transportation trips will be less than 60 minutes in 2022	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	12/31/2022	PACE Center Manager
~~QI21.28 QI22.24~~	Improve Participant Experience	Transportation	≥92% of all transportation rides will be on-time in 2022	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2022	PACE Center Manager
~~QI21.29 QI22.25~~	Improve Participant Experience	Transportation	≥92% on the Overall Satisfaction with Transportation Services - Weighted Average (2021 PACE National Average) on the 2022 PACE Satisfaction Survey	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 Transportation program	Quarterly	01/01/2022	PACE Center Manager
~~QI21.30 QI22.26~~	Improve Participant Experience	Increase Participant Satisfaction with Meals	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Annually	12/31/2022	PACE Center Manager
~~QI21.31 QI22.27~~	Improve Participant Experience	Increase Overall Participant Satisfaction	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	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	12/31/2022	PACE Director

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CALOPTIMA PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
QUALITY IMPROVEMENT PLAN DESCRIPTION

2022

PACE Quality Improvement Subcommittee Chairperson:

Richard Helmer, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

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

Board of Directors Chairperson:

Andrew Do **Date**
Supervisor, First District

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the CalOptima PACE QI 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 QI 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 the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
    - Ensure the QI program involves all providers of care within the PACE program.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
    - Share results of QI identified benchmarks 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 staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).

- Ensure that all levels of care are consistent with professionally recognized standards of practice.
- Assure compliance with regulatory requirements of all responsible agencies.

- **Improve the participant 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 (e.g., menu selection and PMAC).
    - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
    - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration
    - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advanced Health Care Directives which honors members' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
    - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) 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 investigate any potential infractions in the quality of care provided in these settings.
    - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
    - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
    - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care**
    - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
    - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
    - 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.
    - Monitor and track falls occurring in the PACE Day Center and in the home and within the community.
    - Monitor and track the use of opioids at high dosages.
    - Meet or exceed community standards for credentialing of licensed providers.
    - Monitor staff and contractors to ensure that appropriate standards of care are met.
- **Ensure appropriate access and availability.**
    - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
    - Monitor and analyze access to specialty care
    - Continue to develop the network of Alternate Care Setting (ACS) 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

CalOptima Board of Directors provides oversight and direction to CalOptima PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima — including the CalOptima PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima's 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 QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI 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 to address quality problems in any clinical or administrative process that have been identified as critical to participants, families or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, Manager of Community-Based Programs, and PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues 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.

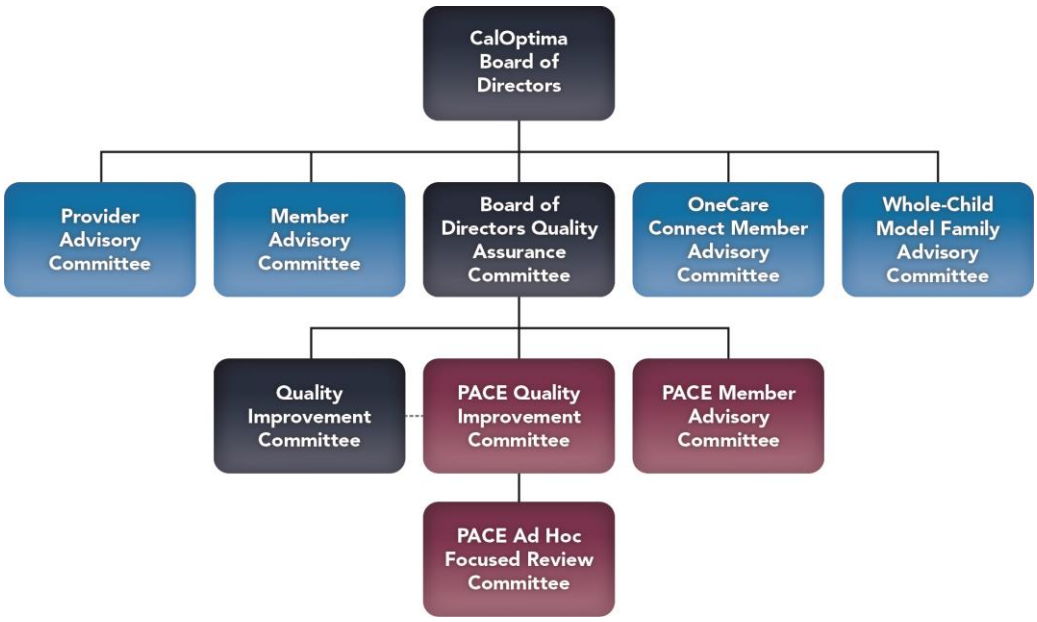
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Manager or PACE QI 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.

PACE Member Advisory Committee

Purpose
PMAC provides recommendations 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 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. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and all interested participants are invited to join. 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 chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2022 Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- 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 underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback 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 PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days for controllable reasons.

- The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.

Clinically Relevant HPMS Data

- Unusual Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
    - Influenza Immunizations Rates
    - Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enrolled in the program in December 2021
    - COVID-19 Immunization Rates
        - Exclusion criteria:
            - Participants who enrolled in the program in December 2022
    - Infection Control: Respiratory Infection Rates
    - Advanced Health Care Planning: POLST Completion
    - Advance Health Care Planning: Advanced Health Care Directive Completion
    - Diabetes Care: Annual Eye Exams
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during measurement year
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2021
    - Diabetes Care: Nephropathy Monitoring and Blood Pressure Control
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during 2021
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2021
                - Participants with End Stage Renal Disease
    - Monitoring of treatment for Participants with Osteoporosis
    - Falls at Home Classified as CMS Reportable Quality Incidents
    - Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Continuous enrollment throughout year
                - Participants who are 66 years and older as of December 31, 2021

- Exclusion criteria:
    - Participants who are end of life (less than six months)
    - Participants with Schizophrenia or Bipolar Disorder
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDs
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Continuous enrollment throughout year
            - Participants who are 66 years and older as of December 31, 2021
        - Exclusion criteria:
            - Participants who are end of life (less than six months)
- Opioids at High Dosage Monitoring
- Medication Reconciliation Post Discharge
- Access to Specialty Care

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.
- Annual competency evaluations of PACE staff.
- PACE staff will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight to all activities offered by PACE.
- Member grievances will be forwarded to the PACE QI Department for investigation, 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 the results of the investigations, 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 appeals will be forwarded to the PACE QI Department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be 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 IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.

- Continued integration of telehealth to expand access to care through the COVID-19 pandemic and beyond.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will monitor transportation services with periodic ride alongs. The times gathered during the ride alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant satisfaction surveys as well as comments solicited by the 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.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- 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

- 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 PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and SAA to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events), 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 HPMS. The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
    - 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 injuries acquired while enrolled in PACE.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
    - Elopement by cognitively impaired participant
    - Adverse drug reactions
    - Foodborne outbreak
    - Burns 2nd degree or higher
    - COVID-19 infections
- HOS-M
    - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting 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) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant 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-Evaluation and 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.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's three quality initiatives in 2022 are:
    - COVID-19 Booster Vaccine Quality Initiative.
        - This initiative will focus on vaccine education, outreach, and vaccine distribution coordination with a goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022.
    - Telehealth Engagement Quality Initiative
        - This initiative will focus on accelerating the adoption and utilization of telehealth by the PACE participants. It will involve education, training and ensuring our participants have the hardware to utilize our telehealth services. The PACE Community Based Services Program Manager will implement a plan to increase prt telehealth access. The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.
    - Advance Health Care Directive
        - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2022.

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI 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 QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

2022 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.01	Improve the Quality of Care for Participants	2021 PACE QAPI Plan and Work Plan Annual Evaluation	2021 PACE QAPI Plan will be evaluated by March 1st, 2022	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2022	PACE Medical Director
QI22.02	Improve the Quality of Care for Participants	2022 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2022	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2022	PACE Medical Director
QI22.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2022	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2022	12/31/2022	PACE Clinical Operations Manager
QI22.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2022	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager
QI22.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥95% of eligible participants will have had their COVID-19 vaccination by December 31st, 2022	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager
QI22.06	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2022	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	12/31/2022	PACE Clinical Operations Manager and PACE Clinical Medical Director
QI22.07	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
QI22.08	Improve the Quality of Care for Participants	Diabetes Care	> 82.77% of Diabetics will have an Annual Eye Exam (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
QI22.09	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
QI22.10	Improve the Quality of Care for Participants	Osteoporosis	>= 90% of participants with the diagnosis of Osteporosis will have treatment initiated by PCP	PACE participants with diagnosis of osteoporosis witll be managed by their PCP using appropriate therapy resulting in a decrease risk of fracture.	Quarterly	01/01/2022	PACE Clinical Medical Director
QI22.11	Ensure the Safety of Clinical Care	Falls at Home Clasified as CMS Reportable Quality Incidents	<= 207 Falls per 1000 per year	Falls with Injury will be mornitored by PACE QI department who will work with the interdisciplinary teams and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<27.24% (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
QI22.13	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	<3.47% (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	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	12/31/2022	PACE Clinical Medical Director
QI22.14	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 of 90 MME/day will be reevaluated monthly by their treating provider in 2022.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2022	PACE Clinical Medical Director
QI22.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 15 days of hospital discharge in 2022	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2022	PACE Pharmacist
QI22.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥85% of specialty care authorizations will be scheduled within 14 business days in 2022 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2022	PACE Clinical Operations Manager
QI22.17	Ensure Appropriate Access and Availability	Improve Access to PACE Care: Increase Telehealth Engagement	≥66% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2022	Community-Based Program Manager
QI22.18	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 hospital days per 1000 per year	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	12/31/2022	PACE Clinical Director
QI22.19	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<850 emergency room visits per 1000 per year	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	12/31/2022	PACE Clinical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.20	Ensure Appropriate Use of Resources	**30-Day All Cause Readmission Rates**	<14% 30-day all cause readmission	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	12/31/202	PACE Clinical Director
QI22.21	Ensure Appropriate Use of Resources	**Long Term Care Placement**	<4% of members will reside in long term care	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	12/31/2022	PACE Center Manager
QI22.22	Improve Participant Experience	**Enrollment/Disenrollment**	Increase the Qualified Lead to Enrollment conversion rate to 60% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2022	PACE Marketing and Enrollment Manager
QI22.23	Improve Participant Experience	**Transportation**	l00% of transportation trips will be less than 60 minutes in 2022	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	12/31/2022	PACE Center Manager
QI22.24	Improve Participant Experience	**Transportation**	≥92% of all transportation rides will be on-time in 2022	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2022	PACE Center Manager
QI22.25	Improve Participant Experience	**Transportation**	≥92% on the Overall Satisfaction with Transportation Services - Weighted Average (2021 PACE National Average) on the 2022 PACE Satisfaction Survey	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 Transportation program	Quarterly	12/31/2022	PACE Center Manager
QI22.26	Improve Participant Experience	**Increase Participant Satisfaction with Meals**	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Annually	12/31/2022	PACE Center Manager
QI22.27	Improve Participant Experience	**Increase Overall Participant Satisfaction**	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	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	12/31/2022	PACE Director

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PACE

CalOptima

A Public Agency

Better. Together.

2021 PACE Quality Improvement (QI) Workplan Evaluation and 2022 Workplan

Quality Assurance Committee
March 9, 2022

Monica Macias
PACE Director

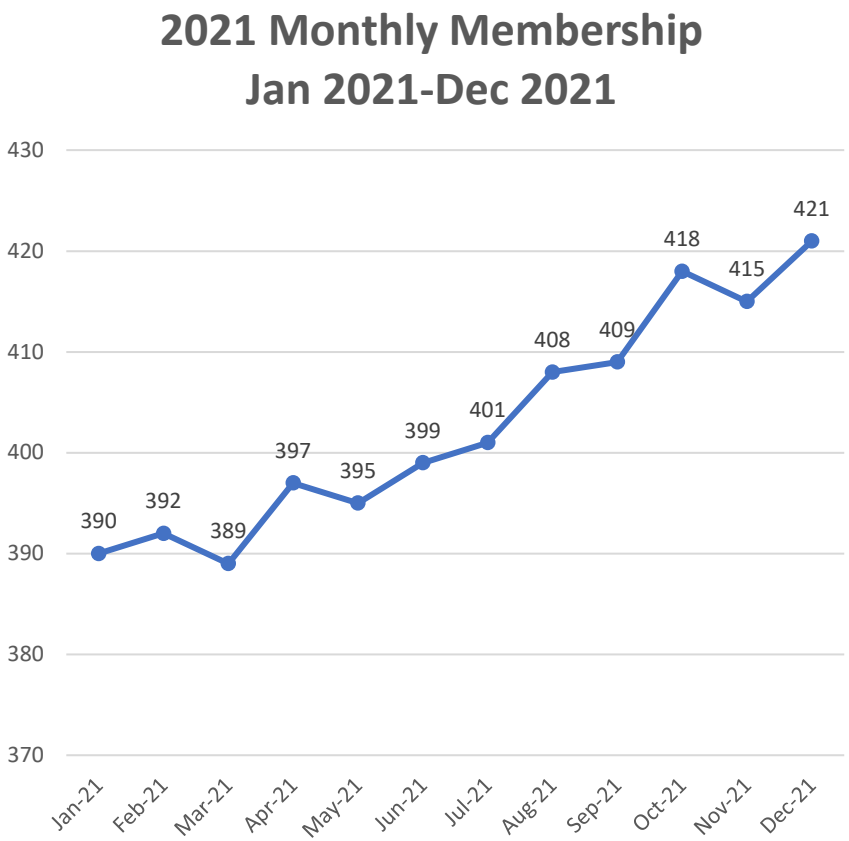
2021 PACE Accomplishments

- Swift response to updated regulation regarding the COVID-19 pandemic, to follow all federal, state, and local guidance.
- Only 2.8% of participants resided in Long-Term Care
- 94% pneumococcal immunization rate
- 91% influenza immunization rate
- 96% COVID-19 immunization rate
- Quality of Diabetes Care
  - 95% had annual eye exam completed
  - 100% had nephropathy monitoring
  - 89% had blood pressure controlled

2021 PACE Accomplishments

- 100% medication reconciliation rate following a hospital discharge
- 91% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
- Transportation with 30,696 one-way trips with an on-time performance of 99%
- Overall participant satisfaction score of 91% compared to national average of 88.5%
- Met 25 of 29 work plan element goals

PACE Membership Growth 2013-2021



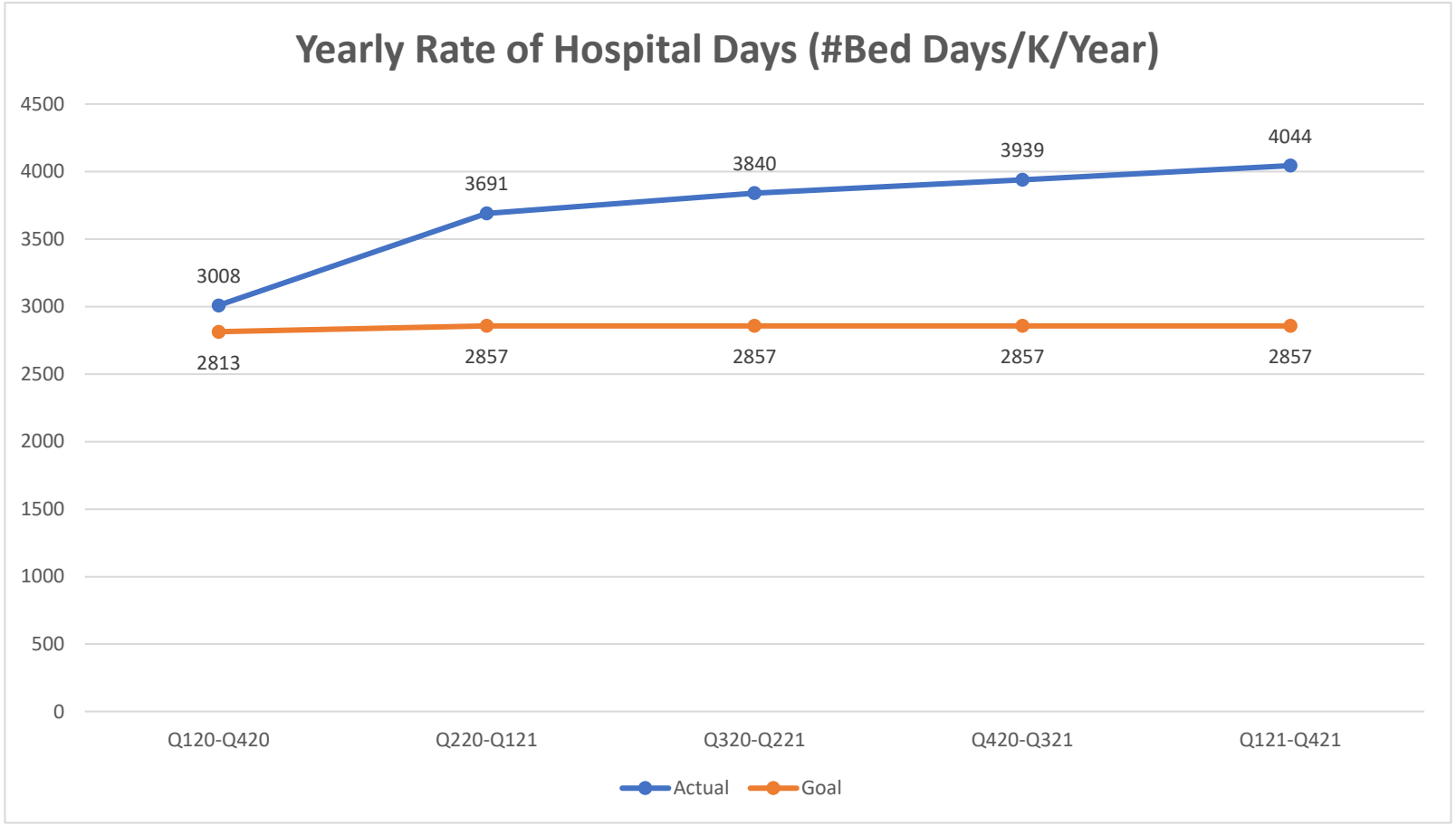
Elements 8-10: Comprehensive Diabetes Care

Higher Is Better		Medicare Quality Compass 2019 HEDIS Percentiles			
Domain	**2021 PACE Rate**	50th Percentile	75th Percentile	**90th Percentile**	**95th Percentile**
Annual Diabetic Eye Exams	**95%**	75.28%	82%	85.33%	**87.10%**
Nephropathy Monitoring	**100%**	95.95%	97.08%	98.30%	**98.78%**
Blood Pressure Control	**89%**	69.53%	76.56%	81.50%	**84.91%**

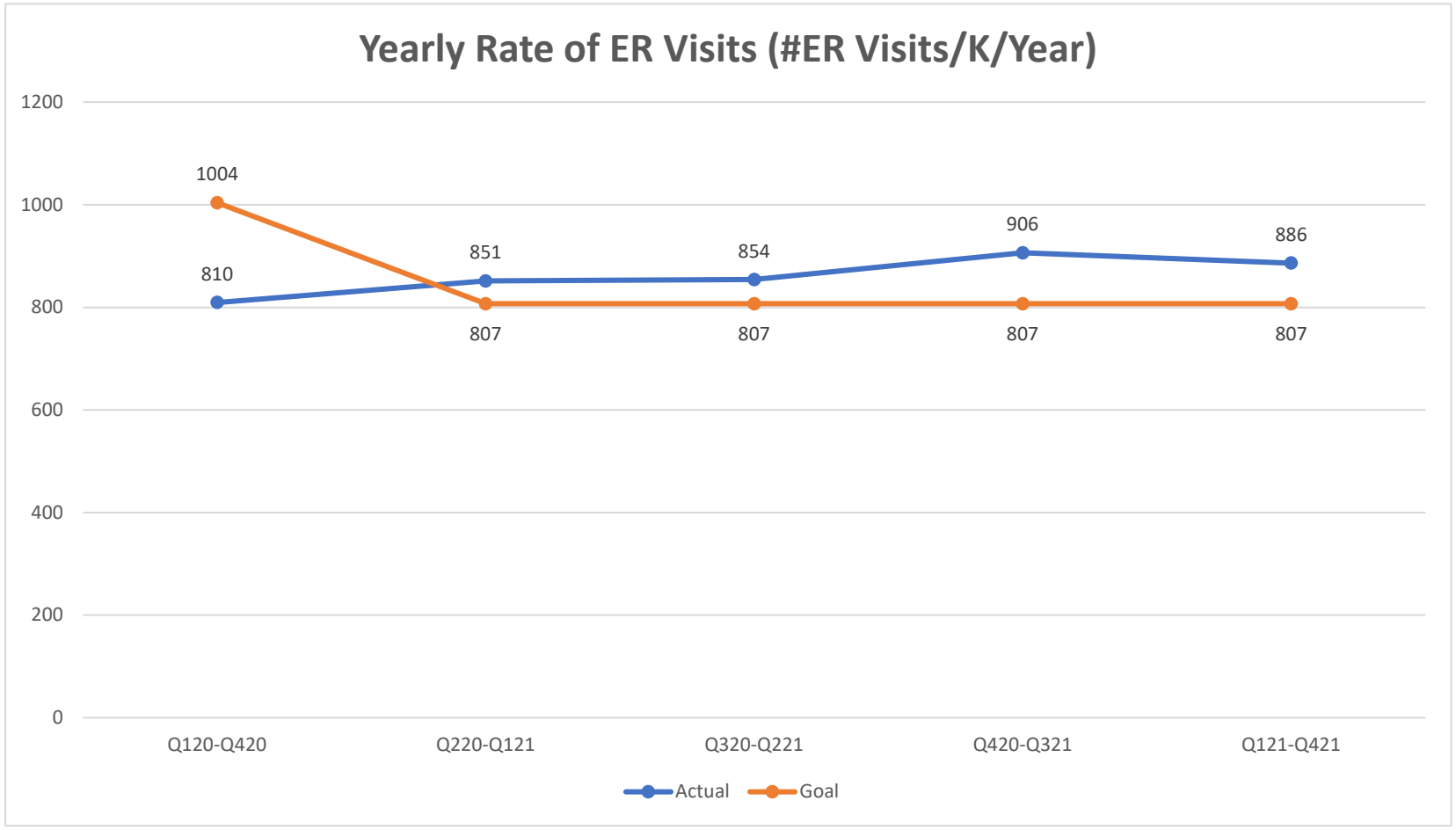
Elements 12–13: Potential Harmful Drug/Disease Interactions in the Elderly

Lower Is Better		Medicare Quality Compass 2019 HEDIS Percentiles			
Domain	**2021 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
Dementia + Tricyclic Antidepressants or anticholinergic Agents	**17%**	44.44%	40%	35.73	**33.96%**
Chronic Renal Failure + NSAID	**0%**	9.31%	6.36%	3.90%	**2.47%**

Element 17: Hospital Bed Days (Goal: <2857 Bed Days/K/Year)



Element 18: ER Visits (Goal: <807 ER Visits/K/Year)



Element 25: Annual Participant Satisfaction Survey Results (Goal: 88% on Overall Weighted Score)

Domain	2020 CalOptima PACE	2021 CalOptima PACE	2021 National PACE Average
Transportation	95%	96%	93.6%
Center Aids	96%	95%	91.2%
Home Care	90%	90%	86.2%
Medical Care	91%	93%	90.1%
Health Care Specialist	87%	88%	89.1%
Social Worker	93%	97%	94.5%
Meals	78%	80%	70.8%
Rehabilitation Therapy and Exercise	87%	91%	93.1%
Recreational Therapy	85%	81%	79.0%
General Service Delivery	85%	92%	86.9%
Overall Weighted Score	89%	91%	88.5%

Opportunities for Improvement in 2022

- Quality and Safety of Clinical Care
  - Add COVID-19 booster related quality initiative for 2022
  - Monitor participants with Osteoporosis diagnosis to ensure that they are receiving treatment to prevent fractures.
- Ensure Appropriate Access and Availability
  - Continued use of the PACE telehealth program
  - Reopening of the PACE day center based on safety
- Ensure the Appropriate Use of Resources
  - Continue the Emergency Room Diversion program
  - Increase the number of PACE core specialists willing to work closely with the PACE program

2022 PACE Quality Improvement (QI) 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
- Updated to address the COVID-19 pandemic, including three 2022 quality initiatives

2022 PACE QI 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
- Additional Focus on COVID-19

2022 PACE QI Work Plan Elements Removed, Added and Modified

- Removed:
  - *Infection Control: Respiratory Rates*. Consistently above benchmark
  - *Care for Older Adults (COA): Functional Status Assessment.* Consistently at 100% and this is tracked elsewhere as a regulatory issue.
  - *Advanced Care Planning: Advance Health Care Directive*. This will now be a **Quality Initiative** for 2022
  - *Enrollment/Disenrollment: Disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%.* Consistently above benchmark. Will continue to monitor as an operational issue.

2022 PACE QI Work Plan Elements Removed, Added and Modified Cont.

- Added a new Quality Element
    1. Monitoring of participants with diagnosis of Osteoporosis to ensure appropriate management of disease. >= 90% of participants with the diagnosis of Osteoporosis will have treatment initiated by PCP
- Modified Falls Element
    1. Changed Falls related element to focus on prevention of Falls with Injury
- Total of 27 QI Work Plan Goals in 2022

2022 Quality Initiatives

- COVID-19 Vaccine Booster Quality Initiative:
  - Goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022.
- Telehealth Engagement Quality Initiative
  - The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.
- Advance Health Care Directive
  - The goal for 2022 is ≥ 50% of participants having a completed AHCD in 2022.

Recommended Action

- Recommend approval of the 2022 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

Our Mission

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

CalOptima Board of Directors'
Quality Assurance Committee Meeting
March 9, 2022
PACE Member Advisory Committee (PMAC) Update

Committee Overview
The PACE Member Advisory Committee meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima PACE leadership on the PACE program care delivery system. The committee is comprised of primarily PACE participants.

PMAC Meeting December 15, 2021

Updates from the Director
Director Monica Macias thanked PMAC members for joining the sixth virtual committee meeting. Members were updated on the status of the program. The PACE center continues to serve a small number of participants for day center services. The clinic and skilled rehabilitation appointments continue to operate as usual. Wellness kits are delivered to participant residences 1-2 times per month and wellness calls are being made daily to address any concerns that our participants may have. Director also introduced our Quality and Improvement Interim Manager, Jennifer Robinson. In addition, Director Monica shared that our current transportation vendor is continuing their recruitment efforts for a manager to support transportation operations.

COVID-19 Updates
Jennifer Robinson, QI Manager, Interim, provided updates related to COVID numbers and status. Jennifer shared that PACE would continue with mask mandates and temperature checks. PACE currently has 97% of participants who have received both doses. Jennifer also shared that many efforts have been in place to get our participants boosted. Jennifer shared that we have a new variant, Omicron and we are monitoring the variant, at this time it's too soon to know the impact this may have. Jennifer reassured the participants that PACE will keep a close eye on this new variant and provide updates.

PMAC Member Forum
- A participant shared feeling appreciative of what PACE staff are doing, particularly due to the current job climate, he felt that everyone is doing a great job.
- Another participant shared his desire to support any marketing efforts and the possibility of speaking to stakeholders regarding our wonderful program and need for growth.
- Most participants continue to express their wishes to return to "normal" and would like an update at the next PMAC meeting regarding day center attendance.

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CalOptima Board of Directors'
Quality Assurance Committee Meeting
March 9, 2022

Quality Improvement Committee Fourth Quarter 2021 Report

Summary

- Quality Improvement Committee (QIC) met on October 12, November 9, and December 14, 2021.
- The following subcommittees and departments reported to QIC in Quarter 4 (Q4):
  - Utilization Management Committee (UMC)
  - Whole-Child Model Clinical Advisory Committee (WCM CAC)
  - Credentialing and Peer Review Committee (CPRC)
  - Member Experience Committee (MEMX)
  - Grievance & Appeals Resolution Services Committee (GARS)
- Approved and filed the following:
  - Quality Improvement Committee Charter
- Accepted and filed minutes and Quality Improvement (QI) Work Plan from the following committees and subcommittees:
  - UMC meeting minutes: August 26, 2021
  - BMSC meeting minutes: April 28, 2021, May 26, 2021, and June 23, 2021
  - WCM CAC meeting minutes: June 15, 2021
  - MEMX meeting minutes: August 09, 2021, and September 15, 2021
  - GARS meeting minutes: September 1, 2021
  - WCM CAC meeting minutes: June 15, 2021
  - 2021 Quality Improvement (QI) Work Plan Q3
- Change in Quality Improvement Committee Members
  - Dr. Mayorga stepped down from Committee to take a seat on CalOptima Board of Directors (BOD).
  - Dr. Sinha transitioned from HN Physician Committee Member to a CalOptima Medical Director.
  - Dr. Collins, Dr. Fonda, and Tracy Hitzeman departed from CalOptima.

QIC Quarter 3 Highlights

- **Chief Medical Officer (CMO) Updates** — Each month at QIC, the CMO provides an update on COVID-19-related activities and CalOptima statistics and updates. As of the December 14, 2021, QIC meeting, CalOptima membership had grown to 870K members and 65% of members 12 and over have been fully vaccinated for COVID-19. These presentations are also usually presented at Quality Assurance Committee (QAC) and Board of Directors (BOD) meetings.

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- **Behavioral Health Integration (BHI)**
  - **BH Clinical Quality Measures** – Natalie Zavala presented on the Behavioral Health (BH) Quality Measures and interventions for improvement:
    - Follow-up care for children with prescribed ADHD medication (ADD) interventions include 30-day limit for initial fill of ADHD medication to encourage members to follow-up with their prescriber within 30 days and member/provider education on the importance of follow-up visits.
    - Follow-up after hospitalization (FUH) for mental illness within seven or 30 days after discharge include member outreach post-discharge to coordinate follow-up appointments and efforts to improve non-medical transportation for follow-up visits.
    - Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF) and Antidepressant Medication Management (AMM) interventions include provider education and fact sheets for member education along with education on social media sites.
  - **BHI Incentive Programs (BHIIP)** – Natalie Zavala presented that in Q3 91% of the milestones were completed and $1,155,366 milestone incentives were submitted to DHCS. Q4 milestone reporting template to be submitted to DHCS by March 1, 2022. Staff is processing the incentive funding from DHCS for Q2 - $1,215,934, and Q3 - $1,155,366. Staff is collaborating with providers to submit DHCS deliverable of Performance Measure Status Report for each provider which will highlight the performance measures that the providers will establish for Program Year 1 as the baseline and Program Year 2 as the performance measurement year.
- **Long-Term Services and Supports (LTSS)**
  - **Orange County Nursing Facility COVID-19 Prevention Training** – In partnership with Orange County Health Care Agency (OCHA) and the University of California, Irvine (UCI), CalOptima provided COVID-19 support to 12 OC nursing homes to improve prevention readiness and restrict, to the extent possible, the impact of the anticipated COVID-19 surge. Video montages, toolkits, consultative services, and webinars were provided to all OC nursing homes free of charge.
  - **Post-Acute Infection Prevention Quality Incentive (PIPQI**) – LTSS nurses are visiting between 10-12 facilities per week. The PIPQI Team is relaunching branded PIPQI training materials to education nursing facilities on infection prevention protocols and making quarterly payments to each participating facility based on the number of licensed beds. Nurses are also observing invoices and inventory as well as Monthly HAI (Healthcare Associated Infection) Rates to improve the product purchase vs. utilization. Dr. Fonda reported a 40% decrease in COVID cases among members and 30% decrease in staff.
- **UMC**
  - A UM report was presented to QIC by the Manager of Utilization Management Kathie Mutter, which included data presented at the August 26, 2021, committee meeting. UM operational performance and goals were presented. Goals were met for all lines of business, except for Bed days and Readmissions. Over and underutilization dashboard along with

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UM Medi-Cal and OCC Measure trends. Q2 2020 Operational Performance for Whole Child Model population was also shared.
  - Benefit Management Subcommittee (BMSC) meetings were held April 28, 2021, May 26, 2021, and June 3, 2021. Codes were reviewed.
  - Medi-Cal Underutilization Monitoring of Q2 2021 was presented by Dr. Kris Gericke
  - BHI UM update was presented by Ellen Burditt, and she shared an increase in Psychiatric PTMPY in November 2020 related to rapid implementation of telehealth.
- **Pay for Value (P4V) Performance 2020 –** P4V payments were distributed to health networks.
- **Quality Withhold for OneCare Connect –** Sandeep Mital, Manager of Quality Analytics, shared preliminary analysis of CY2021 (DY7) Q2 results showed that five of the ten measures passed, and one measure was pending. Having 50% of the measures passing will result in 25% of withhold OCC receives. Analysis of CY2020 (DY6) Q4 results showed 80% of the measures passing resulting in 100% of withhold OCC receives.
- **HEDIS Measurement Year (MY) 2021 –** To improve childhood immunization performance, staff is using Family Link ID and member address to link a parent CIN to a child CIN.
- **Member Experience –** Marsha Choo presented an update on the Member Experience subcommittee that met on August 9, 2021, and September 15, 2021. OneCare Connect (OCC) Disenrollment Survey and 2021 Member Experience (CAHPS) Survey Results were presented.
  - **2020 Timely Access and In-Office Wait Time Surveys** - CalOptima fielded a Timely Access Survey to monitor telephone and appointment wait times of members from November 2020 thru May 2021 with a sample size of 3,629. Improvements were seen for almost every measure, but efforts are needed to improve PCP and Specialist appointment wait times, particular for urgent appointments, and compliance with telephone recording and call back times. Non-compliant providers were sent a notification letter with escalation, if applicable, and HNs not meeting the minimum performance will be issued corrective action.
  - **Network Adequacy Update** - 2020 Timely Access and In-Office Wait Time Surveys have concluded. 2021 Timely Access Survey fielding began mid-September 2021 and health networks, and providers were notified of the survey cycle.
  - **Member Experience Workplan Updates** - mPulse (Member Texting) COVID-19 immunization campaigns continue. Virtual visits with PACE clinicians continue with PACE Telehealth Solutions (VSee) where 10% of encounters were tied to telehealth and there was a 63% member engagement. eConsult Initiative are in process to finalize contract negotiations. Fifty-nine provider contracts were executed to expand the provider network.
- **Population Health Management (PHM)**
  - Helen Syn presented an update on Quality of Clinical Care Intervention Strategy sharing a list of multi-model member engagement activities. Staff is collaborating with other organizations on upcoming events to support that include CalOptima's Escape the Vape - Great American Smokeout 2021 and community vaccination events to increase flu and COVID-19 vaccination rates as well as focusing on the Flu and COVID-19 Vaccination Campaign.

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  - Quality of Clinical Care and Improvement Projects are in progress including two new improvement projects on cervical cancer screening and child and adolescent immunization rates.
- **Case Management**
  - Sloane Petrillo, Director of Case Management presented update on CalOptima's Health Risk Assessment for Q2 2021 that had a 99-100% completion rate. OCC ICP bundles met 100% of networks performance threshold for both initial and annual. OCC ICP completion within 90 days of enrollment is on an upward trend at 87.0%.
  - Homeless Health Initiative – In person visits to sites are on pause for regular visits due to the public health emergency, however staff is assisting by virtual and telephonic outreach. Clinical Field Teams continue with both in person and telehealth visits.
- **WCM CAC**
  - Dr. Thanh-Tam Nguyen presented a summary of the WCM CAC meeting held August 17, 2021, where Dr. Fonda shared a 49% WCM member COVID vaccination rate and Pshyra Jones gave an update from the previous meeting on CalOptima's efforts to support WCM member and families who participate in the Shape Your Life (SYL) program. Staff will target WCM population to enhance the program. There was also an update on Whole-Child Model Measures. Grievance and Resolution Services, Whole-Child Model Customer Service Inquiries as well as WCM vs. Non WCM Top Call Categories.
- **CPRC**
  - Laura Guest presented an update on CPRC. Final DHCS All-Plan Letter (APL) 20-006 and corresponding documents had not yet been released. Staff will report to QIC at the next report with any new updates.
  - Site Review Activity – There was an increase of PCP Corrective Action Plan's issued for FSR's. Staff is looking into the cause of increase.
  - Credentialing - CalOptima credentialing scored 100% in the NCQA credentialing audit that occurred July12-13, 2021. There was a decrease in the turnaround time for providers to complete credentialing from 55 days to 40 days for Initial applications and from 90 days to 42 days for recredentialing.
  - PQI - There was a sharp decline of PQIs, likely due to the change in workflow for Quality of Care grievances.
- **GARS**
  - Zulema Gomez presented an update on grievance and appeals trends
    - **Medi-Cal Member Grievances** – There was an overall decrease in Medi-Cal complaints, but Quality of Service continues to be the highest grievance category followed by Access grievances. Quality of Service grievances are highest for CCN, related to referral and service delays and provider/staff grievances, and with our transportation vendor, Veyo, for late pick-ups and no shows.
    - **Medi-Cal Behavioral Health Grievances** – There was a slight increase in overall BH grievances with an increase in access grievances related to appointment availability and telephone access and in quality of service related to delays in service.

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- **OneCare Connect Member Grievances** – There was a 6% increase in total complaints with Quality of Service continues to be the highest grievance category related to Veyo transportation services and overall provider staff. While there was an increase in access grievances, this category only accounts for 4% of all the grievances.
- **OneCare Connect Behavioral Health Grievances** – Behavioral Health grievances decreased by 60% and remains low.
- **OneCare Member Grievances** – There was 103% increase in total complaints where majority of grievances are related to transportation and provider/staff demeanor and services.

Attachments

2021 Quality Improvement Work Plan – Third Quarter 2021

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2021 QI Work Plan
3Q Update

2021 QI Work Plan Element Description	Planned Activities	Staff Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red-At Risk Yellow-Concern Green-On Target
I. PROGRAM OVERSIGHT					
2021 QI Annual Oversight of Program and Work Plan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Esther Okajima	Approved: QIC 1/12/2021, QAC 2/25/21, BOD 4/1/21		
2020 QI Program Evaluation	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Esther Okajima	Approved: QIC QIC 1/12/2021, QAC 2/25/21, BOD 4/1/21		
2021 UM Program	UM Program will be adopted on an annual basis.	Mike Shook	2021 UM Program approved QIC 2/16/21, QAC 2/25/21, BOD 3/4/2021		
2020 UM Program Evaluation	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Mike Shook	2020 UM Evaluation approved QIC 2/16/21, QAC 2/25/21, BOD 3/4/2021		
Population Health Management Strategy	Review and adopt on an annual basis.	Pshyra Jones	Strategy is complete and current.		
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	M. Choo/Laura Guest	1) The number of providers credentialed and recredentialed remained consistent with an uptick in Q3. We had no 805 reporting's in Q3. We completed the NCQA Audit Q3 and scored 100% on all Credentialing elements. 2) As of June 30, 2021, the flexibilities provided in DHCS APL 20-011-Executive Order N-55-20 terminated. Effective July 1, 2021, CalOptima resumed on-site FSR and PARS activities for all contracted providers. Q3 FSR Productivity: 80 FSRs, 85 MRRs and 96 PARS. 43 CAPs issued for critical elements. 3 PCP panels were closed (1 failed FSR, 2 failed MRRs). 3) The number of new PQIs continue to decline due to the new GARS/PQI Process (addressed in row 36), and the number of cases presented to CPRC remained consistent. For Quality of Care cases, the greatest issue continued to be Medical Care. 4) In 2020, due to the COVID-19 public health emergency, no on-site audits for nursing facilities or CBAS centers were completed. On-site audits of nursing facilities resumed in Q3 2021. Annual virtual audits of the CBAS centers continue to be performed (Q3 2020 – current).	1) In Credentialing, we continue to perform on-going monitoring of the CalOptima provider network, and will take action of providers on any exclusion or preclusion list. QI Credentialing has 100% compliance for Recreds in Q3. 2) FSR and PARS are continuing to complete the backlog of audits due to suspension of on-site activities. Additionally, FSR and PARS due since the resumption of on-site activities are being completed by the assigned due dates. 3) For PQIs, we are moving more of our outcomes to a CAP-model so that we can follow-up with providers with issues. 4) As the CDPH has resumed performing recertificate surveys, on-site audits of the NF are also being completed. CDA and DHCS have not yet authorized CBAS centers to open or allow on-site audits. Annual virtual audits of the CBAS centers continue to be performed. On-site audits will resume when authorization by CDA and DHCS is granted.	
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Tyronda Moses	Member and Provider Complaints Q2 results were shared at the Sept 14, 2021 QIC Meeting. There was a 17% increase in Total Complaints, 39% increase in member appeals, 15% increase in member grievances, 16% increase in provider appeals. **Medi-Cal Grievances:** QOS continues to be the highest Grievance category. QOS increased by 26% from Q1 to Q2, Access increased by 17%, QOC decreased by 7%. **Medical BH Grievances:** 18% increase in BH grievances 363 grievances filed by 338 unique members, Access continues to increase, this quarter it increased 58% (from 29 in Q4 to 116 in Q1 to 183 in Q2, Billing increased by 120% - out of pocket reimbursement requests for office visits QOS decreased by 11%, QOC decreased by 26% **OneCare Connect Complaints:** 47% increase in total complaints, 50% increase in appeals, 67% increase in grievances, 6% decrease in provider appeals, QOS continues to be the highest Grievance category. QOS increased by 86% from Q1 to Q2, mainly in transportation grievances, QOC increased by 50%, Access decreased by 48% **OneCare Connect BH Grievances:** Behavioral Health grievances remain low, but doubled from Q1 to Q2. Majority of the grievances were service-related issues **OneCare Complaints:** 8% decrease in total complaints, 11% decrease in member appeals, 50% increase in member grievances 44% decrease in provider appeals.	1) Grievance trends are reviewed for repeated issues. 2) High grievance count by providers are tracked and trended. 3) Results are shared with a Provider Action workgroup for recommended action or escalation to the Member Experience Committee.	

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2021 QI Work Plan
3Q Update

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Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.	The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Kelly Rex-Kimmet/Marsha Choo	In Q3, MEMX Committee has reviewed /discussed the following in Q3 meetings (8/9 and 9/15) •NCQA Survey Update *MemX Workplan •OCC Disentollment survey •2021 Member Experience CAHPS Survey Results •Customer Service Intervention Discussion Cont. •Best Practice: Neighborhodd Member Advocate	In Q4 MEMX Committee has a meeting schedule for October 13 and December 8.	
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.	UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Mike Shook	UMC reported to QIC on 7/20/2021. Presented 2021 1st Quarter and Annual Trends (5/27/2021), 1Q 2021 Operational Performance, 1Q 2021 Utilization Outcomes, Q1 2021 Operational Performance WCM, 2020 CCN Over/Under Utilization Monitoring, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BH UM, BHI. QIC accepted and filed meeting minutes from UMC Meeting (5/27/21).QIC Accepted and filed all documents.	UMC is scheduled to present Quarterly update to QIC on 10/12/2021.	
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.	Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	T.T. Nguyen, MD	WCM CAC gave an update to QIC on 8/10/2021. WCM CAC pproved 2/25/2021 Meeting Minutes. Dr. Fonda gave COVID-19 ralated issues Update, Pshyra in PHM presented information on Shape Your Life weight management program for WCM members, Behavioral Health shared referral services and collaborative work that is being performed with the County, RX transition was still on hold, WCM CS Inquires provided a report that included inpatient/outpatient authorization referral denial. Next WCM CAC meeting is scheduleded for 8/17/2021.	WCM CAC will give an update to QIC is on 11/16/2021. They will present an update on WCM Quality Measures, Pharmac Medi-Cal RX update, WCM Measures, GARS, WCM CS Inquires, DHCS Notce Updates	
Quality Withhold for OCC	Monitor and report to QIC	Kelly Rex-Kimmet/ Sandeep Mital	Per a memo released by CMS dated July 29, 2020, in light of the impacts from the Corona-virus disease and public health emergency, Medicare-Medicaid plans (MMPs) will automatically receive the full quality withhold payment of 100% from CMS and the state for CY2020, provided that the MMP fully reports all applicable quality withhold measures.	Pay for Value team will continue to monitor CalOptima performance on all quality withhold measures for MY2021.As of September 30, 2021 CalOptima has passed 5 of 10 total number of measures and is expected to meet 8 of 10 measures for 100% payment for MY2021. CMS has announced that "extreme circumstances" will not be applied to MY2021 performance.	
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, Collaboration with OC Coalition of Clinics to receive their aggregated EMR data, efforts to immunization registry (CAIR) and lab data gaps (Blood Lead Testing results for example) Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital	**Data Mining:** Hepatitis B vaccine can be given as early as on the date of birth. However, the babies most likely have not been assigned a CIN during the first a few months after birth. The claims for the hepatitis B vaccination could be billed under their parent's CIN and will not be counted for HEDIS Childhood Immunization Status measure. CalOptima developed logic to identify hepatitis B vaccines for infants billed under their parents' CINs by using the Newborn Hepatitis B Vaccine Administered value set (ICD10PCS) and Hepatitis B Vaccine Procedure value set (CPT/HCPCS) codes during the first 60 days after birth. We connect the parents' CINs back to their children's CINs through the Family Link ID and member address. The Scope & Design document for HepB billed under parent's CIN is completed. If approved by the HEDIS auditors, this may positively impact the Childhood Immunizations Measure for HEDIS MY2021. **NCQA update:** NCQA is integrating health equity for future state HEDIS measures. Five Medicaid measures will be required to be reported by race and ethnicity for MY2022. The number of measures to be reported by race/ethnicity will expand in MY2023 and MY2024. The measures for MY2022 are: • Controlling Blood Pressure • A1C Control • Prenatal Care • Postpartum Care • Child and Adolescent Well Care Visits CalOptima started to receive the blood lead screen data from the State quarterly in 2021. The data contains two sources: 1) California Department Public Health lead screen test registry (CDPH) and 2) Department of Health Care Services (DHCS) medical claims. Of a[[rpved by the HEDIS auditors, the data will be mapped to the NCQA certified HEDIS software Inovalon QSI-XL ECDS template and used as supplemental data for MY2021.	1) Submit to HEDIS auditors for approval. 2) Provide NCQA and DHCS MPL measures update to QIC Q4.	

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Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in Orange County; (from QOC: Adult's Access to Preventive/Ambulatory Health Services (AAP) 2) Improving well-care visits for children in the 15 months of life (W15) **MC QIP:** 1) COVID QIP Workplan - Impact of COVID-19 - across all measures **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% **MC and OCC QIP:** Improving Statin Use for People with Diabetes (SPD) **PPME (OC)- Sloane:** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC)- Sloane:** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) **PDSA:** 1) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents- Michelle Findlater - **CMS Onhold** 2) Improving Cervical Cancer Screening Rates through Provider Engagement	Helen Syn/Sloane Petrillo/Michelle Findlater	CMS has announced that "extreme circumstances" will not be applied to MY2021 performance. Incentive dollars earned will be based upon the number of measures the plan achieves established benchmarks.	1) Continue expansion of virtual outreach. 2) On Hold due to PHE 3) Continue current process 4) Continue current process	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	1. Monitor the 12 projects approved by DHCS for the BHI Incentive Program. CalOptima will be responsible for program oversight, including readiness, milestones tracking, reporting and incentive reimbursement. Quarterly program update at QIC. 2. Monthly provider report on two metrics: % of BCBA supervision and % of utilized direct service hours. The ABA P4V will be available to all contracted ABA providers starting January 2021. Incentive will be paid out in Q1 2022.	Natalie Zavala/Sheri Hopson	1) BHIIP - 6 of the 7 provider groups completed 88% of the milestones expected to be completed in Q2; milestone reporting template completed by due date 8/27/21. A corrective action plan (CAP) was developed and issued to 1 provider group experiencing challenges implementing their project and fulfilling milestones; provider requesting to revise project. Quality Analytics (QA) collected data and completed the performance measures reporting template highlighting 2020 baseline performance measures results for each provider group/project and submitted to DHCS by 8/27/21 and shared with the provider groups. BHI, RAC and QA had a conference call with DHCS to address previously submitted questions pertaining to the performance measures report. DHCS requested BHI to question provider groups about their ability to gather data and report the required performance measures; poll results were submitted to DHCS. Incentive payments for QI milestones have not yet been received. 2) ABA P4V - June and July report cards were sent to ABA providers in August. The calculation for the ABAU metric was revised to only reflect utilization percentage for the code H2019/1:1 services.	1) BHIIP - Providers are expected to complete their Q3 milestones by 9/30/21 and submit their reporting template and supporting documentation to BH by 10/30/21. BH to review the reports/supporting documentation and compile the Q3 milestone reporting template for the November submission. 2) BHIIP - DHCS to provide guidance for two unresolved topics: BHIIP providers requesting to revise their project and providers' capability to report the required performance measures as outlined in their application and MOU. 3) ABA P4V - Generate August report card, inform providers the ABAU metric has been updated to reflect results for H2019 1:1 service only.	
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 3. Primary point of contact for coordinating care with collaborating partners and HNs 4. Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Sloane Petrillo	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 Virtual outreach to one shelter. Planned engagement with another shelter. 2) Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 Telephonic outreach to members when they are called for CFT visit. 3) Primary point of contact for coordinating care with collaborating partners and HNs This is being done. 4) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19 Mary's Kitchen outreach in September.	1) Continue expansion of virtual outreach. 2) On Hold due to PHE 3) Continue current process 4) Continue current process	

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Homeless Health Initiatives (HHI): Health Homes Program Phase 2	1. Incorporate new data to DHCS reporting re: Housing Navigation. 2. Streamline process for referrals to HHP. 3. Enhance oversight of program. 4. Developed process to coordinate referral with County for members with SMI.. 5. Focus on telephonic outreach d/t COVID-19 6. Addition of supervisor to Homeless Team to provide additional support for the program.	Sloane Petrillo	1) Incorporate new data to DHCS reporting re: Housing Navigation. This is ongoing and being reported. 2) Streamline process for referrals to HHP. Completed 3) Enhance oversight of program. Deferred as program is ending on 12/31/2021 4) Developed process to coordinate referral with County for members with SMI.This was done in prior quarters and meeting in Q4 with BH regarding. 5) Focus on telephonic outreach d/t COVID-19 Yes ongoing telephonic 6) Addition of supervisor to Homeless Team to provide additional support for the program. Supervisor position is open and will backfill.	1) Continue new process 2) Complete 3) Enhanced oversight being developed for CalAIM; all HHP members will transition into CalAIM on 1/1/2022 4) Complete. 5) Complete. 6) In Process.	
Health Equity	1. Make health equity a strategic priority 2. Develop structure and process to support health equity work 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4. Develop partnerships with community organizations to improve health and equity 5. Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Pshyra Jones/Marie Jeannis	1) Alignment the CalOptima health equity framework with the Orange County Health Care Agency efforts 2) Hire Associate Director of Population Health Initiatives - primary responsibility is to work with Strategic Development Team to support organizational efforts 3) CalOptima participation in the ACAP SDOH Learning Collaborative	1) Present health equity framework project plan to senior leadership 2) Heallth Equity Framework kick off meeting with CalOptima department leads	
II. QUALITY OF CLINICAL CARE- Adult Wellness					
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	1) Continue $25 member incentive program for completing a CCS. 2) Targeted member engagement and outreach campaigns to promote cervical cancer screenings in coordination with health network partners 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach campaigns 5) Member Health Rewards RFP and Vendor Contract 1) Continue member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy) 3) Targeted member engagement and outreach campaigns to promote colorectal cancer screenings in coordination with health network partners 4) Member Health Rewards RFP and Vendor Contract 1) Continue $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted member engagement outreach campaigns to promote breast cancer screenings in coordination with health network partners. 3) Coordinate mobile mammography clinics in zip codes with low incidence of screening. 4) Track the number of mammograms scheduled through targeted outreach. 5) Member Health Rewards RFP and Vendor Contract	Pshyra Jones/ Helen Syn	1) Member Health Rewards are available on CalOptima Website, and shared with all Health Networks to promote in their outreach campaigns. 2) # of BCS 2021 Member Health Rewards processed as of 10/18/21: 297 for Medi-Cal, 5 for OC, and 63 for OCC # of CCS 2021 Member Health Rewards processed as of 10/18/21: 406 for Medi-Cal # of Colorectal CS 2021 Member Health Rewards processed as of 10/18/21: 2 for OC and 33 for OCC 2. 2021 August Prospective Rates (PR): Breast Cancer Screening MC: 49.28%, OC: 55.41%, OCC: 54.53% Measure is performing lower for all LOBs than same time last year and below the 50th percentile (MPL). Rate is negatively impacted by the COVID-19 pandemic. Members are not going in for preventive care visits. Cervical Cancer Screening MC: 51.47% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Rate is negatively impacted by the COVID-19 pandemic. Members are not going in for preventive care visits. Colorectal Cancer Screening OC: 45.49%, OCC: 47.99% Measure is performing better than same time last year for OC and lower than same time last year for OCC and is currently below the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going in for preventive care visits	1) Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. 2) Community Mobile Mammography events in collaboration with community partners and community clinics scheduled for remainder of year. 3) Member Health Reward and Member Engagement Vendor Selected. Contract pending and program for member engagement likely to begin in Q1 2022. 4) Social Media Posts: October for Breast Cancer Awareness Month; January 2022 for Cervical Cancer Awareness Month; March 2022 for Colorectal Cancer Awareness Month	

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COVID-19 Vaccination and Communication Strategy	1) Implement immunization strategy for CalOptima adult members 16 years and older 2) Create Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions. - Mailing to all members with info on the vaccine - Targeted outreach via text messaging campaign. When different priority groups become available to be vaccinated, we send out targeted messages to these members letting them know that: a. They are now eligible to be vaccinated. b. Where they need to go to be vaccinated (when available) c. This is also likely to begin in February, but may extend into the fall depending on the vaccine distribution timeline. - Targeted outreach via phone calls to targeted groups of people who are at high risk for not getting the vaccine. 3) Implement Incentive Strategy for COVID-19 vaccination a.Coordinate efforts with OC HCA Vaccine Sites and Health Networks to distribute $25 nonmonetary gift cards after the first and second doses b.Coordinate efforts with the Coalition to distribute $25 food voucher to local restaurants after the first and second doses for members experiencing housing insecurity	Pshyra Jones/ Helen Syn/	1) Continued ongoing communication efforts (social media, instagram, community announcemets, website) to build confidence and suppor of COVID-19 vaccine 2) Completed several text campaigns to support vaccinations for homebound members and CalOptima mobile vaccine clinics 3) Member outreach to CalOptima CCN members 4) Promoting CaalOptima/County vaccine events via mobile texting. PHM staff to be a resource for CalOptima/County vaccine events. Onsite distribution of member health reward to CalOptima eligible members.	1) Continue ongoing communication efforts 2) Pivot outreach strategy to highlight members in scope for the APL 21-010 Medi-Cal COVID-19 Vaccination Incentive Program - trusted messenger campaigns - additional outreach to homebound members - Create educational materials to support caregivers - update FAQs on the website - identify appropriate messaging for COVID-19 boosters, and emergency use authorizaion for children 5-11 years - PBS campaign efforts 3) Support Kaiser with member health rewards distribution	
III. QUALITY OF CLINICAL CARE- Behavioral Health					
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	1) Visit additional hospitals with inpatient psychiatric unit to discuss CalOptima concurrent review and transition of care process 2) Use strategies to engage and motivate members to participate in their own care 3) Collaborate with the two BHI Incentive Prgoram projects to improve follow up after hospitalization	Natalie Zavala	PR HEDIS Rates (August) Q3: 30 day- 41.46%, 7 day- 26.83% 1) Continued outreach to members post-discharge to coordinate follow-up appointments. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions. 3) Relationships with providers and members have continually improved bringing an increase in member/provider engagement. 4) Addressed transportation barrier for members by PCC arranging for NMT for f/u visits. 5) Resistance from a facility has been an issue (i.e., sharing info or setting up aftercare plan or discharge appt info). Issue shared with to PR who provided education on importance of coordination of care.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those not attending follow-up appointments within 7 days of discharge. 3) Continue conducting comparison between prospective rates and CORE report data for consistency. 4) Identify at least 1 intervention in the next BHI Incentive Program Learning Collaborative that can be implemented to improve follow up.	
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.	1) Continue the non-compliant providers letter activity 2) Conduct member outreach to improve appointment scheduling 3) Update and distribute member and provider educational materials for ADD	Natalie Zavala	PR HEDIS Rates (August) Q3: Initiation Phase- 40.41%, Continuation and Maintenance Phase- 47.92% 1) Pharmacy related intervention placing a 30-day limit for the initial fill of ADHD medication to encourage members to follow up with the prescriber within 30 days continues. 2) Distributed provider letter via email/fax to non-compliant BH Providers with Pharmacy Update Fact Sheet for ADD. 3) Updated CORE report to track members who filled an initial ADHD Rx. This will be a more manual process, but addresses barrier of limited resources for developing a real-time report to track member f/u visits for provider outreach to schedule visits. 4) Developed process for member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members).	1) Conduct member outreach for those who filled an initial ADHD prescription. 2) Create article to submit by November deadline for Spring edition of member newsletter to educate on importance of attending f/u visits with provider.	
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 2 educational events on depression screening and treatment 3) Continue to educate providers on depression screening via provider newsletters 4) Continue to educate members on depression and the imortance of screening and follow up visits via member newsletters and other social media.	Natalie Zavala	PR HEDIS Rates (August) Q3: N/A; Not at risk for meeting the standard due to no benchmark set, however there are some barriers in implementing activities. 1) Data collection continues to be a major challenge due to the lack of mechanisms for capturing provider data. 2) HEDIS reporting tip sheet on hold due to code issues. 3) Distributed provider letter on importance of screening for depression and encouraging them to share factsheet with members they are serving via telehealth due to pandemic in July. 4) The 2021 Summer edition Medi-Cal newsletter included the *Understanding Depression* article discussing symptoms of depression and importance of screenings; mailed to members in July and uploaded to CalOptima website in September. Additional member materials posted on social media (i.e., Instagram and Facebook).	1) Continue to educate members on depression and importance of speaking with providers regarding their symptoms through social media (i.e., Instagram and Facebook).	

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2021 QI Work Plan
3Q Update

2021 QI Work Plan Element Description	Planned Activities	Staff Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red-At Risk Yellow-Concern Green-On Target
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.	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Educate members the importance of depression medication adherence via member newsletters and social media.	Natalie Zavala	PR HEDIS Rates (August) Q3: MC 45.83%, OC 57.58%, OCC 57.11% 1) Distribute provider letter on reminding members of importance of medication adherence and encouraging them to share factsheet with members they are serving via telehealth due to pandemic in July. 2) Finalizing HEDIS reporting tip sheet for provider education. 3) The 2021 Summer edition Medi-Cal newsletter included the *Understanding Depression* article on depression and importance of medication adherence mailed to members in July and upload on CalOptima website in September. Additional member materials posted on social media (i.e., Instagram and Facebook).	1) Complete and distribute HEDIS tip sheet for provider education. 2) Continue educating members on depression and the importance of treatment adherence through social media (i.e., Instagram and Facebook).	
IV. QUALITY OF CLINICAL CARE- Chronic Conditions					
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Control (this measure evaluates % of members with poor A1C control-lower rate is better)	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out 2) Targeted member engagement and outreach campaigns to promote Diabetes A1C testing in coordination with health network partners 3) Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot 4) Member Health Rewards RFP and Vendor Contract 5) Prop 56 provider value based payments for diabetes care measures	Pshyra Jones/ Helen Syn	1) Member Health Rewards are available on CalOptima Website, and shared with all Health Networks to promote in their outreach campaigns. 2) # of A1C Testing 2021 Medi-Cal Member Health Rewards processed as of 10/18/21: 149 3) 2021 August Prospective Rates (PR): CDC A1C Poor Control (>9**)** MC: 60.71% OC: 50.65%, OCC: 48.37% Measure is performing **better** than same time last year (lower is better) for MC, but has not yet reached the 33rd percentile (MPL). Measure is performing better than same time last year (lower is better) for OC & OCC but has not yet reached the 25th percentile (MPL).	1) Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. 2)Diabetic members who had an A1C <8% but are not over 8% will receive health coach outreach once next set of data is available in November. 3) Member Health Reward and Member Engagement Vendor Selected. Contract pending and program for member engagement likely to begin in Q1 2022. 4) CCN A1C Control intervention and outreach for members and providers in planning stages. 5) Diabetes Awareness Month Social Media post slated for distribution on 10/25/2021	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization 4) Targeted member engagement and outreach campaigns to promote Diabetes Eye Exam in coordination with health network partners 5) Member Health Rewards RFP and Vendor Contract 6) Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot 7) Prop 56 provider value based payments for diabetes care measures	Pshyra Jones/ Helen Syn	1) Member Health Rewards are available on CalOptima Website, and shared with all Health Networks to promote in their outreach campaigns. 2) # of Eye Exam 2021 Medi-Cal Member Health Rewards processed as of 10/18/21: 101 3) Diabetic member eligibilty file specifications being ironed out between CalOptima and VSP. 4) 2021 August Prospective Rates (PR): CDC Eye Exam MC: 43.85% OC: 56.47% OCC: 55.95% Measure is performing better than same time last year for MC, but has not yet reached the 33rd percentile (MPL). Measure is performing better than same time last year for OC & OCC but has not yet reached the 25th percentile (MPL).	1) Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. 2) VSP eligibility file upload identifying diabetic members completion Q4 3) Member Health Reward and Member Engagement Vendor Selected. Contract pending and program for member engagement likely to begin in Q1 2022. 4) Diabetes Awareness Month Social Media post slated for distribution on 10/25/2021	

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V. QUALITY OF CLINICAL CARE- Maternal Child Health					
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	1) Continue $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments 5) Member Health Rewards RFP and Vendor Contract 6) Implement Collaborative Member Engagement Event with OC Diaper Bank (3-4 times yearly) 7) Prop 56 provider value based performance incentives for prenatal and postpartum care visits nad birth control	Ann Mino	1) Member Health Rewards are available on CalOptima Website, and shared with all Health Networks to promote in their outreach campaigns. 2) Health Reward and Engagement Vendor Selected 3) Total # of PPC health rewards approved for Q3: 135. Total 2021 Member Health Rewards processed as of 10/18/21: 291. 4) Bright Steps outreach to 614 postpartum members, 1013 assessment attempts made, 234 Bright Steps assessment completed.. 5) Planning for Diaper Days events in progress. Tentative dates established. 6) Completed Provider mailing to 28 OB offices to encourage PNR submission and PP Member Health Reward education 7) August 2021 Prospetive Rates: Timeliness of Prenatal Care: 78.65% Measure is performing lower than same time last year and has not met the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Postpartum Care: 61.47% Measure is performing better than same time last year and has not met the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic.	1) Continue prenatal and postpartum assessments 2) Continue to promote Bright Steps with provider, members, and community-based organizations 3) Health Reward and Engagement Vendor contract pending budget approval. 4) Member awareness efforts through member publications in March 2022, social media campaigns.	
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness					
Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations,	1) Targeted outreach campaigns in coordination with health network partners 2) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 3) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents; and track the number of participants for targeted adolescent "Back-to-School" events. 4) Prop 56 provider value based payments for relevant child and adolescent measures	Pshyra Jones/ Helen Syn	**1.** Back-to-School Vaccination Events in collaboration with community partners (July-Sept):Anaheim Union High School District 7/26: Approx. 30 students were vaccinated, Northgate Gonzalez Market 7/31: 44 patients received COVID-Vaccine, Dental screening, Vision screening, or routine Pediatric vaccine.,Westminster Family Resource Center 8/18-8/19: Approx. 85 attendees, and 57 received vaccinations for routine back-to-school or COVID-19, Boys & Girls Clubs of Garden Grove 9/113: Approx. 150 kids and 111 adults served. 10 COVID-19 vaccinations, and 23 well-child screenings and/or school vaccinations **2**. CalOptima's Vaccination Event in collaboration with the community and Westminster Family Resource Center aired on ABC 7 News, 08/2021 **3.** PBS Well Child and Immunization Campaign PSA (ongoing) **4**. Back-To-School (BTS) Vaccination Ads on Social Media: BTS Vaccination Ad: Let's Get Back Together Safely on Social Media, 08/2021, BTS Vaccination Ad: Don't Wait Vaccinate on Social Media, 08/2021, BTS Vaccination Ad: Don't Miss Your Shot on Social Media, 08/2021 **5.** August National Immunization Month: Website, social media and communications campaign on the importance of childhood vaccinations. Included Health Care Chat Video on Back-To-School Routine Vaccinations on Social Media platforms, 08/2021 **6.** Text Message Campaigns: BTS Vaccine Launch (26,061 members), 08/2021 **7.** Medi-Cal Summer Newsletter included, 07/2021: During the COVID-19 Pandemic is it Safe for Well-Care Visits article, Let's Get Back Together Safely ad **8.** Community Connections publications included Back-To-School Vaccination Events in their July Newsletter **9.** Promoted Back-To-School Vaccination events via CalOptima Community [Weekly] Announcements July-September, 2021 **10. 2021 August Prospective Rates (PR): Childhood Immunization Status (CIS)** CIS: 29.84%; Measure is performing better than same time last year. Measure is currently below the 50th percentile. **Immunizations for Adolescents (IMA)** Combo 1: 78.63%; Combo 2: 45.14%; HPV: 47.35%; Meningococcal: 80.76%; Tdap: 85.75%. Measures are performing lower than same time last year. IMA-Combo 2 and HPV submeasure met the 66th Percentile. All other submeasures is currently below the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Members are not going into their PCP's office timely. **Child and Adolescent Well-Care Visits (WCV)** Age 3-11 years: 33.34%; Age 12-17 years: 29.94%; Age 18-21 years: 17.05%; Total: 28.80%. NEW MEASURE. No benchmark has yet been established for MPL. Members are not going into their PCP's office timely. **Well-Child Visits in the First 30 Months of Life (W30)** First 15 months: 6+ Visits: 26.17%; 15 Months - 30 Months: 2+ Visits: 62.45%; NEW MEASURE. No benchmark has yet been established for MPL. Members are not going into their PCP's office timely.	1. Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. - COVID text message campaign emphasizing Preventative Care Planned for Q4 Well Care Visits, Immunizations for members ages 0-30 months and 3-17 years. 2. PBS Well Child and Immunization Campaign PSA - ongoing 3. PBS COVID-19 and Flu Campaign PSA - pending 4. Collaborate with community partners to participate in holiday/vaccination events.	
Blood Lead Screening	1) Create new policy 2) Create quarterly report sent to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 3) Create member and provider educational materials 4)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 5) Prop 56 provider value based payments for Blood Lead Screening	Pshyra Jones/ Helen Syn/ Leslie Martinez	1. Creation of new policy is complete. Policy GG.1717 Blood Lead Screening of Young Children that was approved in QI, is undergoing review and revisions. 2. Quarterly report strategy is complete. Contracted providers received Q3 blood lead screening report on 10/12/2021. Q3 report template contained revisions provided by Health Networks. 3. DHCS supplemental data obtained with CPT codes. Experiencing delays in the receipt of Q3 DHCS blood lead screening supplemental data. 4. Update on BLS and quarterly report shared at Quality Forum. 5. Be Aware of Lead Posters shared with Provider Relations in Q3 for distribution to high volume provider offices. 6. August 2021 Prospective Rates (PR): MC: 57.24%. The 50th percentile is 73.11% Measure is performing lower than same time last year for MC. The measure has not reached the 50th percentile but is not held to the MPL.	1. Member awareness efforts through member publications in March 2022, social media campaigns. 2. Social Media post slated for October 2021 Q4. 3. Identify method to share quarter report to CCN Providers - in progress 4. Distribution of Q4 DHCS supplemental report distribution with CPT codes in January 2022. 5. Distribution Q4 report to Health Networks in January 2022.	

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VII. QUALITY OF SERVICE- Access					
Improve Access: Reducing gaps in provider network	1) Actively recruit hard to access specialties for CCN	Michelle Laughlin/Jennifer Bamberg	In Q3 2021, CalOptima has outreached to providers and contracted with the following: Dermatology – 1 Orthopedic Surgery - 6 Geriatrics – 1 BCBA - 3 LCSW - 3 As of end of Q3: 59 executed agreements, 23 in active negotiation, and 6 in credentialing for the following specialties: Dermatology, Gastroenterology, Nephrology and Orthopedic Surgery. Goal is to recruit 25% of 135 hard to access leads (34 providers).	Continue to pursue contracting with hard to access specialists.	
Improve Access: Timely Access (Appointment Availability)	1) Communication and corrective action to providers not meeting timely access standards 2) See Virtual Care Strategies	Marsha Choo/Jennifer Bamberg	CalOptima fielded the 2020 Timely Access Survey. PCP and Specialist Routine and Urgent visits compliance increase from the previous survey cycle. While PCP and Specialist routine compliance did not improve by 10 percentage points, there was an increase of over 9 percentage points for each measures. A signifiance increase was seen in both PCP and Specialist urgent appointment compliance with an increase of over 40 percentage points. The significant increase may be due to the change in methodology to increase response rate for these measures. This year, urgent appointments were fielded with a direct call methodology.	CalOptma to issued PDSAs to HNs with not compliant with 80% MPL and send notificaiton or warning letters to providers who were non-compliant with the standards.	
Improve Access: Telephone Access	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Provider Outreach and Education (Timely Access Survey)	Marsha Choo/Jennifer Bamberg	To align ourselves with DHCS, CalOptima limited the survey call attempts for the 2020 Timely Access Survey to 3 attempts, which is a change from the previous survey cycle. As a result, the baseline and goal were adjust to reflect 3 attempts. In 2020, the No Live Contacts After 3 Attempts was 29.9% and CalOptima did not meet the goal.	QA will work with provider relations to outreach and educate providers the vendor was unable to reach this survey cycle.	
Improve Access: Virtual Care Strategies	1) Pace Telehealth 2) BH Virtual Care Visit (Bright Heart) 3) e-Visit (After Hours Urgent Care) 4) Participate in eConsult implementation 5) Member Texting Platform (mPulse)	Marsha Choo/Rick Cabral	1) PACE Telehealth: •10% of encounters are telehealth •63% for telehealth engagement 2) BH Virtual Care •BH Virtual Care (Bright Heart)- Bright Heart is limited to members who speak English only. We have reports from members of the lengthy intake process to access services. Bright Heart is given as a provider option when appropriate. 3)e-Visit (After Hours Urgent Care) • Renamed Virtual Visits • Contract completed for RFP 4)eCosult •eConsult contacted Sept-2021 5)mPulse •Member texting campaigns for COVID-19 immunization education and clinics, well child programs and other member education	1) Pace Telehealth •Continue to monitor trends 2) BH Virtual Care Continue to monitor 3) e-Visits •Re-issue RFP •Select vendor, establish contract negotiations and prepare COBAR for Board Approval. •Obtain Board approval for COBAR •Execute contract and plan implementation 4) eConsult •Finalize contract negotiations; Prepare COBAR and Obtain Board Approval; Execute contract and plan implementation 5) mPulse	
VIII. QUALITY OF SERVICE- Member Engagement					
Improve Member Experience: Member Engagement	1) Member Portal 2) Member Outreach Calls	(1)Mauricio Flores (2)AndrewTse /Nancy Martinez	**1)-**Member portal development is focusing on interoperability with future upgrades to Facets and Guiding Care applications. Updating security and user verification. New features to improve self service functions will be developed once interoperability and security upgrades are completed. **2)-** Outreaching efforts involve informing members - specific primary care providers terminating from the plan and assisting members with locating a new primary care provider - who are deeming and educating members on how to resolve their Medi-Cal eligibility issue - who have a share of cost and educating members on contacting social services to assist with share of cost status and/or questions - following up with new enrollees after 45's day of being enrolled with the plan to check in on how everything is working and offer assistance if necessary. - Outreaching to members to wish them a Happy Birthday	**2)** Based on inbound call volume and existing staffing resources, member outreach calls will be conducted	

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IX. SAFETY OF CLINICAL CARE					
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access	Mike Shook	Based on the July 2021 post discharge call data, about 43% of the members discharged from the hospital have a appointment with their PCP within 30 days post discharge. This is the Feb 2021 baseline of 47.3%. Additionally, we are offering assistance with scheduling a PCP appointment at time of the call, but this number remains low.	Meeting with core group of stakeholders within medical management to review and discuss performance, as well as identify intitiatives that may be put in place based on barriers identified to bolster performance. Initial meeting 9/14/2021. First follow up meeting scheduled Friday Oct 1.	
Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing	1) Implement new GARS/PQI process to improve response to quality of care grievances which will include clinical recommendations in the GARS resolution letter to member. 2) Reduce the number of PQIs related to quality of service grievances, and overall PQIs being investigated	Laura Guest/Tyronda Moses	In Q4 2020, we instituted a new GARS/PQI process in response to the Annual DHCS audit and CAP. In the new process, the QI Nurse reviews QOC grievances referred by GARS initially for any urgent clinical issues that need to be addressed. When GARS receives the response from the provider, the QI Nurse summarized the issue, the provider's response and makes recommendations. This is reviewed by the medical director, who makes the final recommendations which are included in the member's grievance resolution letter. The medical director will recommend opening a PQI investigation if more information is needed to determine if there was a quality of care issue. An additional advantage of this process is that it has resulted in a dramatic decline of cases referred by GARS, from an average of 112 per month in 2020 to 14 per month in Q3 2021. In Q3, 2021, PQI closed 128 cases, of which 88 were referred by GARS. Eighty of these cases were leveled as quality of service or no quality of care or quality of service identified..	Have an ongoing review of the process and identify opportunities for improvement or refinement in our methodology.	
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	**Michelle Findlater**/Scott Robinson	1) LTSS PIPQI nurses continue to conduct onsite visits to the 26 Nursing Facilities participating. Staff interview CalOptima Members for protocol understanding and check compliance rates with NF staff. Ongoing training provided to new and seasoned employees. 2) PIPQI Nurses have been collecting data regarding CHG and Iodophor Purchase quantities and reviewing data with NF DSD/IP. Despite multiple efforts(In person, Telephone and E-mail requests), there are nearly 50% of all invoices from the facilities not submitted to the PIPQI team. (35/78 Iodophor missing) (36/78 CHG missing) 2/26 facilities are ordering within 80-100% of the predicted quantities of products (CHG or Iodophor) 15/26 are purchasing less than 50% of the predicted quanities of Iodophor 11/26 and purchasing less than 50% of the CHG predicted quanities 3) Since the return of Onsite visits the average facility HAI score dropped in Quarter 3 from 4.39 to 4.13 based on data given by facilities.	1) LTSS has partnered with Enterprise Analytics to recreate a PIPQI dashboard that views trends regarding HAI scores, and Product Purchasing.The dashboard compares facilities based on which phase of the program they initially enrolled in as well as can be sorted by gerographical location or corportate ownership to find and assess trends. 2) Still pending on the dashboard is claims data related to hospitalizations for MDROs per facility. 3) Continue with current payments based on licensed beds and incentive payments quarterly. 4) Outreach ongoing to all leadership teams at the facilities to educate on the importance of product ordering aligning with facility census.	

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Orange County COVID Nursing Home Prevention Program.	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2021. Planned activities include: 1) Outfit OC nursing homes to prevent COVID-19 as soon as possible 2) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 3) Provide guidance, protocols for preventing spread of COVID 4) Support training on how to stock and use protective gear 5) Develop high compliance processes for protection of staff and residents. 6) Make toolkit available for free at www.ucihealth.org/stopcovid	Cathy Osborn/**Scott Robinson**	May 2020 – CalOptima partnered with Orange County Health Care Agency and the University of California, Irvine (UCI) to provide COVID support to OC nursing homes. UCI developed a toolkit and implemented training to improve prevention readiness and restrict, to the extent possible, the impact of the anticipated COVID-19 surge to Orange County Nursing Homes. 1. Intensive training for 12 nursing homes, including video observations. Video montages of safe and unsafe behavior provided weekly. 2.Toolkit, consultative services and webinars provided to all Orange County nursing homes free of charge. 3. UCI provided vaccine inservices at six nursing homes. 4. UCI launched a COVID prevention helpline to offer guidance and information to nursing home staff. 5. To date, UCI has received over 100 inquires on topics related to vaccines, boosters, and infection prevention guidance (e.g. masking). 6. UCI began training nursing homes using an invisible black light marker to provide feedback in environmental cleaning gaps. 7. UCI began conducting point prevalence sweeps of residents for multi-drug organisms.	1. Continue to meet with UCI monthly for updates. 2. UCI will continue to monitor 12 nursing facilities via video surveillance. 3. UCI will continue point prevalence sweeps or residents for multidrug-resistant organisms and analyze the results. 4. UCI will conduct a point prevalence sweep of staff and residents from 5 nursing homes during the 2021 winter cold/flu season to detect any resurgence of COVID-19. 5. UCI will produce biweekly video montages and quantified tracking of infection prevention practices for the 12 nursing homes to feedback opportunities for improvement and hardwire prevention practices. All training materials available at: www.ucihealth.org/stopcovid	

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Board of Directors' Quality Assurance Committee (QAC) Meeting
March 9, 2021

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
Last Quarter 2021 Meeting Summaries

November 9th, 2021: PACE Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary Q3 HPMS Data and Analysis

- All PQIC members present
- Infection Control Subcommittee: PACE's Response to COVID-19:
    - Continuation of Wellness calls and COVID-screening prior to appointments.
    - 1600 wellness calls made to participants in October 2021.
    - Continued coordination of Covid-19 vaccinations for participants.
    - Day Center reopening on limited basis with COVID-19 protocols in place.
    - Weekly Covid-19 updates are provided during Leadership Meetings.
    - Monthly Covid-19 updates are provided during All-Staff Meetings.
- Presentation of HPMS Elements:
    - Immunizations: Pneumococcal Immunization rate is at 96%. Goal of 94% has been met.
    - Falls Without Injury: Increase in falls without injury in the third quarter were noted, attributed to a loosening of pandemic restrictions and that participants are getting outside more.
    - Grievances: Number of grievances decreased in Quarter 3.
    - Quality Incidents with Root Cause Analysis: 5 falls with injury and 1 pressure ulcer were noted. A root cause analysis is conducted for each quality incident.
    - Covid-19 Vaccine Quality Initiative:
        - Currently 96.3% of participants are fully vaccinated and we have met the goal of 80%.
        - 25 participants have received their booster shot. We are receiving documentations of booster shots for participants who have received the booster vaccine.
        - 3.8% vaccine hesitancy (dropped 0.7% from last report).
    - Telehealth Engagement Quality Initiative:
        - No dedicated resource for telehealth engagement/engagement onboarding is posing a challenge in this initiative. More participants are brought in house. Monica Macias (Director, PACE) will be taking the lead for VSee as well as with Henry Balanza in terms of any discussions that come up.

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        - Google Duo/Facetime will still be qualifying modes of encounter if the flexibility for the public health emergency gets extended past December 31st, 2021.
    - Immunization Dashboard: The number of participants receiving the pneumococcal vaccine is gradually increasing.
    - Rapid Antigen Testing: Unvaccinated participants continue to receive rapid antigen testing prior to any in-person encounters in the clinic.

November 30th, 2021: PACE Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary Q3 QAPI Workplan Review

- All PQIC members present.
- Infection Control Subcommittee: PACE's Response to COVID-19:
    - Discussion of Omicron COVID variant.
    - Discussion of plans for booster clinic to increase number of participants who have received booster doses. Update on number of participants who had already received boosters (47).
    - Discussion of continuation of COVID measures at center including:
        - Continuation of wellness calls.
        - Reopening of Day Center Attendance to a limited number of participants.
        - Staff Covid vaccination status following public health order.
        - Unvaccinated participants continue to be tracked by PACE QI.
- Discussion of Q3 Quality Assurance and Performance Elements
    - Membership continues to steadily rise.
    - Immunizations
        - Pneumococcal Immunization rate is at 96%. Goal of 94% has been met.
        - Covid-19 Immunizations is at 96%. Goal of 80% has been met.
    - POLST
        - Due to pandemic, social workers have not been able to see participants in person. POLST will now be done with assistance from clinic staff/providers.
    - Advanced Health Care Directive. At 44% and above goal of 40%.
    - Function Status Assessment. 100% of participants had functional assessments done on time.
    - Diabetes Care – Blood Pressure Control. At 84% and above goal of 81.50%.
    - Diabetic Care – Diabetic Eye Exams. At 100% and above goal of 85.33%.
    - Diabetic Care – Nephropathy Monitoring. At 100% and above goal of 98.38%,
    - Falls at Home or in the PACE Center. 1 reported at the center at Q3. Therapist provided education. Falls are usually from not following PT's advice or tripping over things (mechanical falls) and medical issues.

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  - Potentially Harmful Drug/Disease Interactions in the Elderly.
    - Dementia – above goal for reduced risk
    - CKD – above goal reduced risk
  - Decrease the Use of Opioids at High Dosage. Met goal of 100%. One participant is receiving a dose greater than 90 MME and both had PCP follow up in Q3.
  - Medication Reconciliation Post Discharge. Consistently at 100%. Noted importance in giving correct meds after ER visit and hospitalization.
  - Access to Specialty Care. Once order is received, it is processed within 10 days. Currently at 92% and met goal of 85%.
  - Telehealth Engagement Quality Initiative:
    - Decreased from 66% to 64% as participant are more seen face-to-face.
    - Consider option for improvement during 2022 workplan discussion.
  - Acute Hospital Days
    - Detailed discussion of acuity of participants, non-compliance with care.
  - Emergency Room Visits
    - Discussion of ER diversion tactics including afterhours phone calls.
  - 30-Day All Cause Readmissions. Readmission rate is low, timely medication reconciliation helps.
  - Long Term Care Placement. Includes custodial. Lower than general CalPACE benchmark.
  - Enrollments/Disenrollments. 1 controllable disenrollment in Q3 new enrollment coordinator joining the team and getting situated. Above in terms of overall goal.
- Discussion of 2021 Workplan Evaluation and 2022 Workplan
  - Detailed discussion of topics assigned to each discipline for oversight and suggestions for improvements.
  - Specific topics included:
    - Influenza Immunization Rates. Including Q1 of following year in next year's reporting.
    - Covid-19 Immunization Rates. QI suggests changing from 80% to 95%. Booster to be added as a new quality initiative.
    - POLST. Operationally the Center Manager will now be responsible for this element.
    - Advanced Health Care Directive. Discussion of how to continue with this element.

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Member Trend Report 3rd Quarter 2021

Quality Assurance Committee
March 9, 2022

Tyronda Moses, Director, Grievance and Appeals

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Definitions

- Appeal: A request by the member for review of any decision to deny, modify or discontinue a covered service
- Grievance: An oral or written expression indicating dissatisfaction with any aspect of a CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction
- Quality of Care (QOC): Concerns regarding care the member received or feels should have been received

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Medi-Cal Summary

Grievances had a slight decrease of 1% from Q2 2021 to Q3 2021

- Attributing factors:
  - Member billing issues
  - Member Quality of Care (QOC) issues
  - Member Quality of Services (QOS) issues
- Remediation:
  - Reviewing for trends for additional outreach/member/provider education
  - On going staff training regarding the QOC process for identifying and process of QOC cases
  - On going staff training regarding the QOS process for identifying difference in QOS vs. QOC

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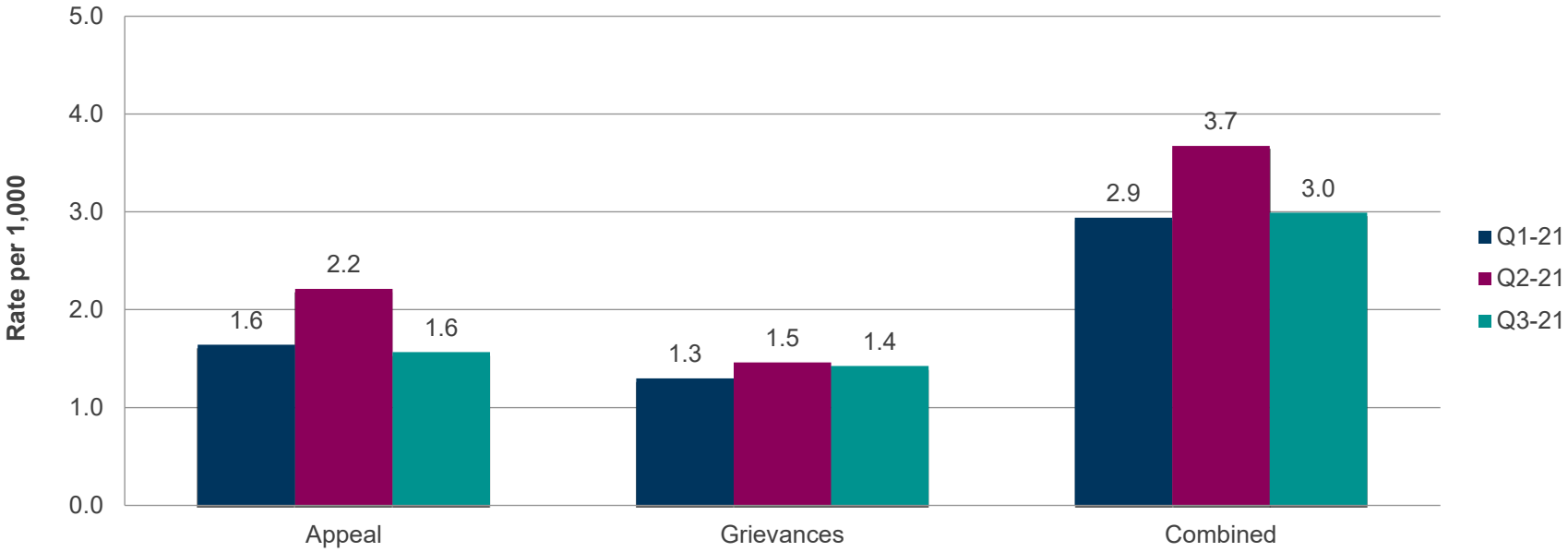
Medi-Cal Total Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2021	3,455	325	3,130	803,071
Q2-2021	4,052	453	3,599	811,976
Q3-2021	3,893	329	3,564	833, 634

Per 1,000 member months for Medi-Cal program

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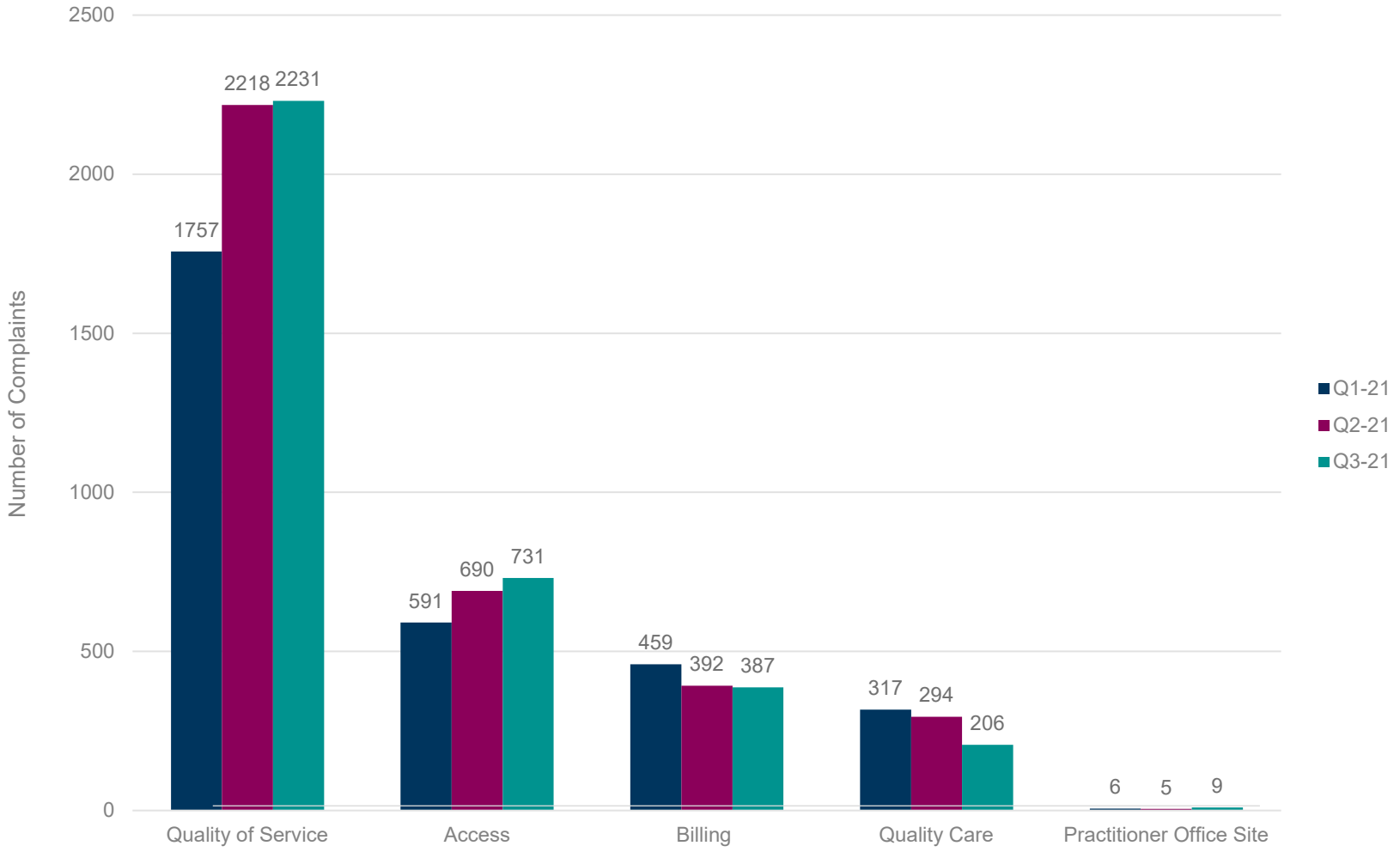
Medi-Cal Grievances by Category



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OneCare Connect Summary

Grievances increased by 15% from Q2 2021 to Q3 2021

- Attributing Factors - Increases were in the following categories:
  - Quality of Service
    - Transportation (Non-medical transportation)
    - Provider/staff demeanor
  - Access
    - Appointment availability
    - Referral/Authorization delays
- Remediation:
    - Reviewing for trends for additional outreach/education
    - Working with our transportation vendor for additional monitoring
    - Education to all stakeholders when incorrect information has been provided

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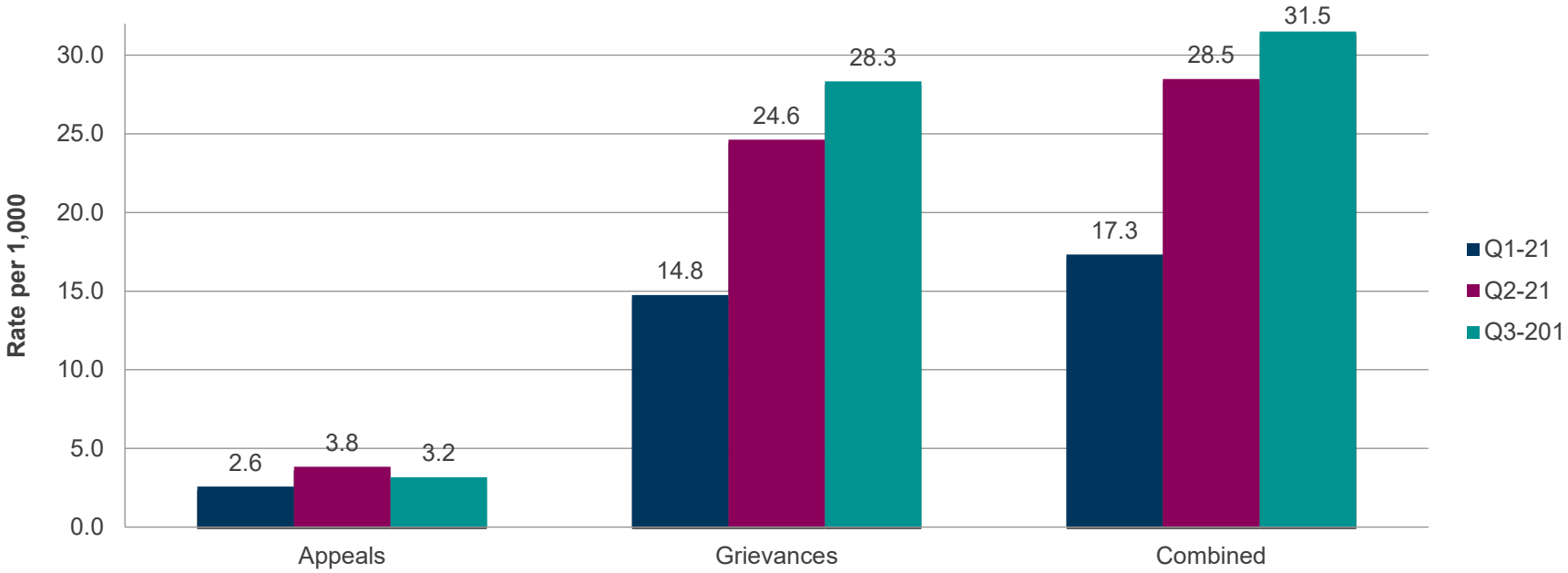
OneCare Connect Total Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2021	256	38	218	14,776
Q2-2021	422	57	365	14,798
Q3-2021	467	47	420	14,828

Per 1,000 members for OneCare Connect program

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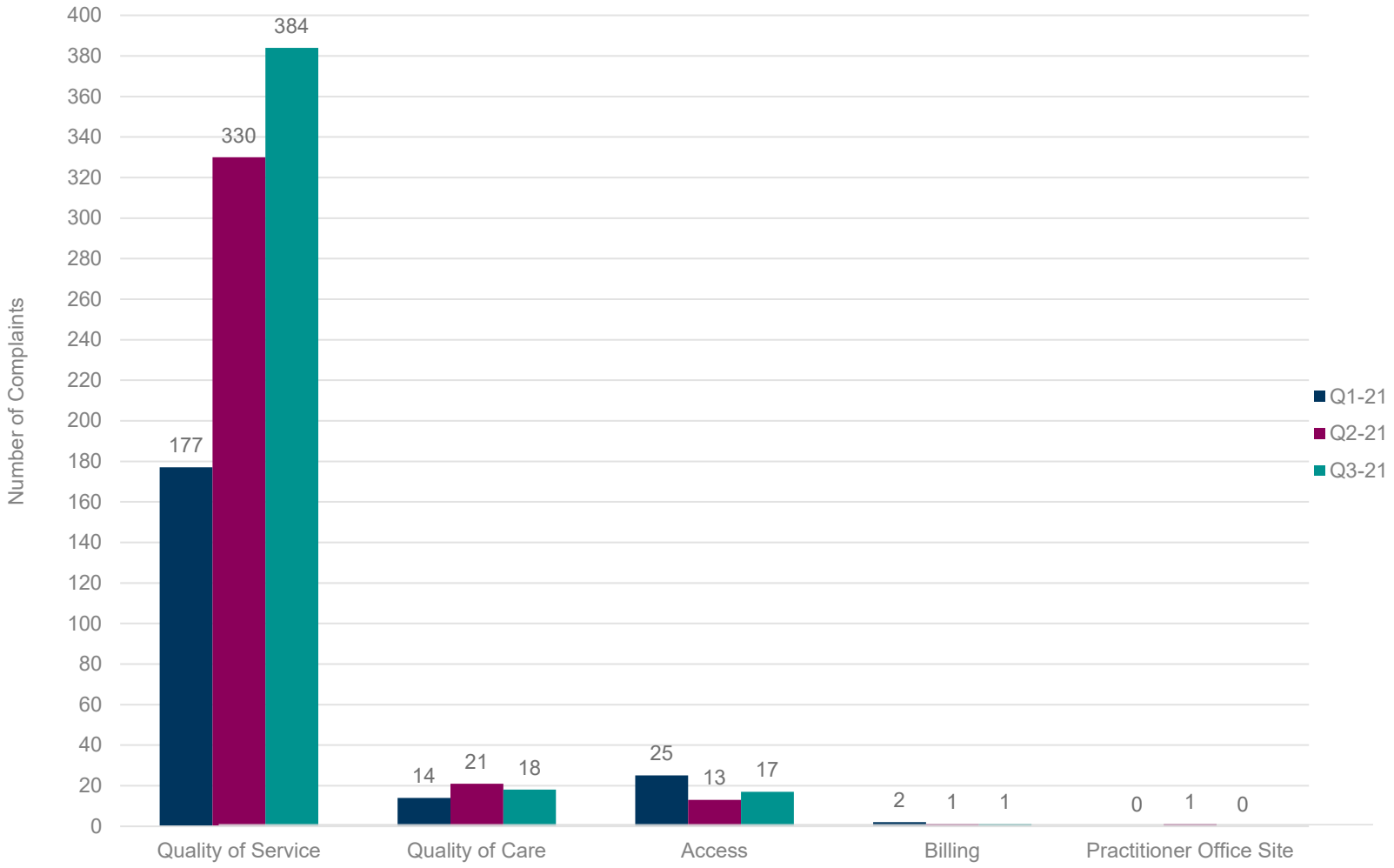
OneCare Connect Grievances by Category



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OneCare Summary

Grievances increased significantly from 18 in Q2 2021 to 42 in Q3 2021

- Attributing factors:
  - Majority of complaints related to Quality of Service such as transportation and internal/HN staff services provided
  - Members with multiple grievances (5 members = 15 cases)

- Remediation:
  - Reviewing for trends for additional outreach/education
  - Working with our transportation vendor for additional monitoring
  - Education to all stakeholders when incorrect information has been provided

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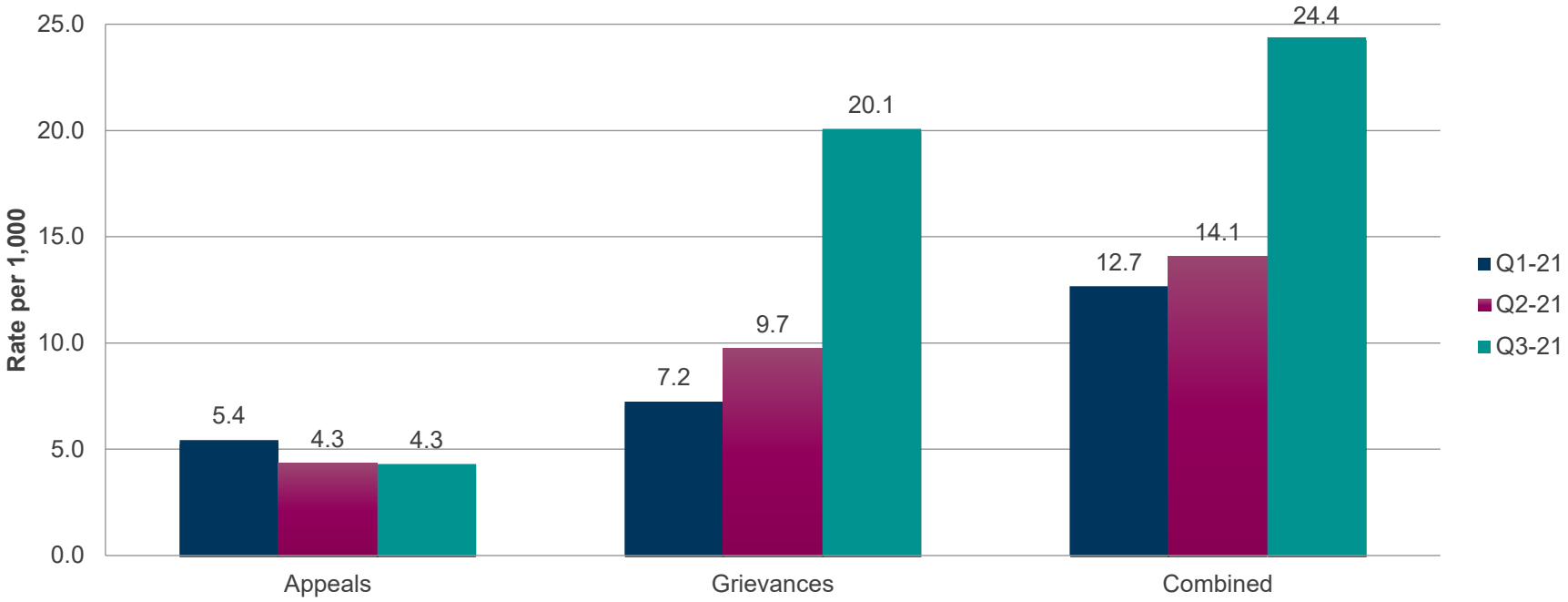
OneCare Total Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2021	21	9	12	1,658
Q2-2021	26	8	18	1,849
Q3-2021	51	9	42	2,092

Per 1,000 members for OneCare program

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Our Mission

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

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