CalOptima Community Network (CCN)

Lunch and Learn Meeting
April 18, 2017
Welcome

Michael German, Manager
Provider Relations
Agenda

• Provider Relations Updates
• Claims Editing Software
• Proper Coding & HCCs
• GARS
• Medical Management Update
• Q&A and Closing Remarks
CCN Meeting Materials

• Meeting Agenda
• Notes page
• CCN Question Sheet
  ➢ Complete if you would like CalOptima staff to follow up with you after this meeting.
• Today’s Meeting Evaluation
  ➢ Please complete at the end of each presentation.
• Meeting materials will be available on the provider webpage at www.caloptima.org after this meeting.
Please place your cell phones on silent
Provider Relations Updates

CCN Lunch and Learn
April 18, 2017

J’neen Abramjian
Provider Relations Representative
Overview

- Community Network (CCN) Membership Update
- CCN Auto-Assignment
- OneCare Connect Authorization Request Form (ARF)
- New Electronic Remittance Advice (ERA)
CCN Membership Update

• Total Medi-Cal Members: 70,502
  ➢ Children: 18,368
  ➢ Adults: 50,066
  ➢ 65 years of age and older: 2,068

• Total OneCare Connect Members: 1,755

• Total Primary Care Providers: 631

• Total Specialists: 3,639

Data as of March 23, 2017
CCN Auto-Assignment

• Effective April 1, 2017, new CalOptima members will no longer be auto-assigned to CCN
  ➢ CCN has an auto-assignment cap once membership reaches 10% of CalOptima’s total membership
• However, members still have the option to request CCN as their designated health network
• Members who wish to make the choice to select a CCN primary care physician can use any of these methods:
  ➢ Customer Service: 714-246-8500 or 888-587-8088
  ➢ CalOptima Website: www.caloptima.org/en/Members.aspx
  ➢ Health Network Selection Form
OneCare Connect ARF

• Effective March 1, 2017, CalOptima created designated ARFs for each line of business (LOB) under CCN:
  ➢ Medi-Cal
  ➢ OneCare Connect (OCC)
• Providers are encouraged to begin utilizing the new ARFs
• Both ARFs will be accepted during a “soft launch” period
• Effective July 1, 2017, ARFs will only be processed according to LOB
  ➢ Member eligibility should determine which ARFs must be used
    ▪ Medi-Cal members on the Medi-Cal ARF
    ▪ OCC members on the OCC ARF
OneCare Connect ARF (cont.)
Electronic Remittance Advice

- Beginning April 12, 2017, CalOptima will provide electronic remittance advice (ERA) to selected providers.
- InstaMed will act as the vendor for ERA, and CalOptima’s partnership with US Bank for electronic funds transfers (EFT) will remain in place.
- Providers will need to register with InstaMed in order to receive ERA/EFT going forward.
- Implementation will be in 3 phases:
  1. Providers that are currently registered with InstaMed.
  2. Providers who receive EFT, but have not registered with InstaMed for ERA – deadline is August 1, 2017.
  3. All remaining providers who have not registered for EFT/ERA.
Electronic Remittance Advice (cont.)

• To register with InstaMed...

Website:
www.instamed.com/payer-payments/clearinghouses.html

Fax:
1-877-755-3392
Questions
Claims Processing — 1Q17
Clinical Editing Patterns and Trends

CCN Lunch and Learn
April 18, 2017

Cesar Tungol
Manager, Claims Administration
CalOptima — Claims Clinical Editing Software Solution (CES)

- CalOptima implemented a Claims Editing Solution (CES) within the core processing system (Facets) late December 2016. The addition of this editing software enables us to manage cost-effective health care and delivery and reimbursement by identifying potentially incorrect code relationships on submitted claims.
- CES is providing real-time automated clinical edits that include prepayment National Correct Coding Initiative (NCCI) edits executed as claims are adjudicated or processed.
- CES utilizes a methodology that prioritizes the edits on each line based on priority edit setting and all edits on a single line can be delivered.
Data represent three months of CES editing and claims submitted for the months of January through March 2017. Results include the Medi-Cal program and five top clinical editing patterns and denials:

- **t60** (16,377 unique claims with 16,415 service lines edited) per National Correct Coding Initiative edits (NCCI), procedure code has an unbundled relationship with a claim or code in claims history.

- **p03** (4,469 unique claims with 7,847 service lines edited) explanation denial code — Unspecified ICD-10-CM diagnosis code. Editing rule looking for specific ICD-10 diagnosis code for services billed, i.e., code which has an equivalent code for laterality (right or left).
CalOptima Claims — CES Data Overview 1Q17 (cont.)

- **p07** (3,666 unique claims with 3,927 service lines edited) per Medi-Cal guidelines, frequency or limits exceeded for services being billed or it does not meet policy requirements for the procedure code.

- **p08** (6,084 unique claims with 7,676 service lines edited) — the required modifier is missing or the modifier is inappropriate for the procedure code.

- **t25** (1,046 unique claims with 1,048 service lines edited) Procedure Code has an incidental relationship with another procedure, i.e., CPT code 94760 has an incidental relationship with code 99213.
CES Editing Rules and Explanation

• p03
  ➢ The flag will invoke when the ICD-10-CM code(s) reported on the claim line define an unspecified ICD-10-CM code which has an equivalent code for right or left, an equivalent code for unilateral or bilateral, or in the instance when the other specified code has a note for unspecified laterality.

• p07
  ➢ The flag will invoke when there is an unbundling relationship with another claim or code in claim history.

• p08
  ➢ The flag will invoke when Medicaid claim lines are missing the required modifier or the modifier appended is invalid or inappropriate for the procedure code.
CES Editing Rules and Explanation (cont.)

• **t25**
  ➢ The flag will invoke when there is an unbundling relationship with another code on the claim.

• **t60**
  ➢ The flag will invoke when there is an unbundling relationship with another claim or code in claim history.
Questions
Best Practices to Support HCC Coding Medicare Risk Adjustment Model

Marty Reza, RHIT, CCS
HCC Coding Specialist Sr.
Health Network Relations
### Session Overview

**Agenda:**

- Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) Risk Adjustment Model
- Chart Documentation Tips
- Claim/Encounter Submission Issues
- CMS Risk Adjustment Data Validation (RADV) Audit
- Available Coding Tips and Tools
Hierarchical Condition Category (HCC)

- The Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) Medicare Risk Adjustment Model

- The current CMS-HCC risk adjustment model is V22
  - Contains more than 3,800 ICD-10CM diagnosis codes
    - Maps to 79 categories (costly/chronic diseases)
  - CMS assigns a Model Relative Factor (demographic score)
    - Based on the enrollee’s age, gender and other socio-economic factors
What’s a Risk Adjustment Factor (RAF)?

• **RAF** = the numeric value assigned by CMS to identify the health status of a beneficiary

• Average RAF score from Medicare = **1.00**
  - Determines coefficients for current year payment
  - RAF score **above** 1.00 = a sicker population
  - RAF score **below** 1.00 = a healthier population
Chart Documentation Tips

• It is key to document all conditions so they accurately reflect the patient’s true severity of illness that impacts patient care:
  ➢ Clinical evaluation (test results, medication’s effectiveness, response to treatment)
  ➢ Document the diagnosis, its status and any causal relationships
  ➢ Therapeutic treatment (any response or changes in treatment)
  ➢ Plan for care (diet, medications, referral, lab/diagnostic orders, patient education, return visits)
Coding Tips for Chronic Conditions

• How often?
  ➢ At each visit, re-assess the patient’s chronic condition(s), code and report based on treatment and care for the conditions.
  ➢ Fully identify the patient’s diabetic conditions when more than one body system is being impacted.
  ➢ This demonstrates a good standard of practice and quality of care.
Chart Documentation

• Why is it so important?
  ➢ To ensure **all** patients’ health conditions are accurately addressed, evaluated, treated and monitored
  ➢ Improves communications between physicians
  ➢ Better identification of members for care management
  ➢ Accurate documentation supports data integrity/chart audits
Documentation/Diagnosis Coding Errors

• Common diagnosis coding errors can affect a member’s actual health status.

• Documentation must support coding to the highest level of specificity.

• Could lead to an inaccurate RAF value:
  - Not documenting the complications or co-morbidities.
  - Omitting the acuity or type of disease
    - (congestive heart failure (CHF) vs. chronic diastolic congestive heart failure)
  - Stage of disease not documented (CKD)
    - (chronic kidney disease (CKD) vs. chronic kidney disease, stage 4)
Dropped HCC codes

• Members must be seen by their PCP annually.
  ➢ When a provider is assigned a new member, it is important for the office to outreach if the member has not been seen in 90 days.

• 77 year old female, dual eligible beneficiary with multiple chronic conditions
  ➢ CMS-HCC model relative factor: 0.611
  ➢ Diabetes with neuropathy (RAF 0.346)
  ➢ Congestive heart failure (RAF 0.368)
    ▪ Member was not seen during the calendar year
    ▪ Overall RAF score: 0.611
  ➢ Member was seen and chronic conditions were addressed and accurately coded
    ▪ Actual RAF score: 1.325
Dropped HCC codes (cont.)

- HCC codes get dropped when the chronic conditions are not re-addressed and coded to the highest level of specificity.
  
  ➢ For example, diabetes with nephropathy coded in 2016; however, diabetes without complications is assigned in 2017.
    
    ▪ HCC 18 diabetes with chronic complications **RAF 0.346**
      • Type 2 diabetes mellitus with diabetic nephropathy E11.21
    ▪ HCC 19 diabetes without complication **RAF 0.097**
      • Type 2 diabetes mellitus without complications E11.9
Dropped HCC codes (cont.)

• Dropped HCC codes significantly affect the RAF scores and consequently result in a lower compensation received to provide care for members with chronic conditions.

➤ During the chart review audit period, if the documentation in the medical record does not support the codes submitted through claims or encounter, CalOptima HCC coding auditors will delete the unsupported code(s).
## Documentation Requirements

### Chronic Kidney Disease (CKD)

When documenting CKD, specify:

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying cause:</td>
<td>• If CKD is related to diabetes (diabetic) or hypertension (hypertensive), document the cause, if known.</td>
</tr>
<tr>
<td>Stage of CKD:</td>
<td>• Stage 1, stage 2 (mild), stage 3 (moderate), stage 4 (severe), stage 5 or end-stage renal disease (ESRD)</td>
</tr>
<tr>
<td>Dialysis dependence:</td>
<td>• Hemodialysis or peritoneal</td>
</tr>
<tr>
<td>Transplant status:</td>
<td>• Document the current stage of CKD “post transplant” (if applicable)</td>
</tr>
</tbody>
</table>

### Major Depressive Disorder (MDD)

When documenting MDD, specify:

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode type:</td>
<td>• Single or recurrent</td>
</tr>
<tr>
<td>Severity:</td>
<td>• Mild, moderate or severe</td>
</tr>
<tr>
<td>Symptoms:</td>
<td>• Presence or absence of psychotic features, or symptoms</td>
</tr>
<tr>
<td>Remission status:</td>
<td>• Partial or full</td>
</tr>
</tbody>
</table>
# Diabetes Specificity

When documenting diabetes, specify:

<table>
<thead>
<tr>
<th>Type of Diabetes:</th>
<th>• Type 1, type 2, or secondary — due to an underlying condition (document first the underlying condition) or postprocedural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control status:</td>
<td>• Controlled, poorly controlled or out of control. If uncontrolled, specify as hyperglycemic or hypoglycemic</td>
</tr>
</tbody>
</table>
| Diabetic complications: | • Diabetic chronic kidney disease (document the stage of the CKD)  
• Diabetic neuropathy, unspecified  
• Diabetic ulcer, (document the ulcer by type, site, depth and laterality)  
• Diabetic glaucoma (document the affected eye, the type and stage)  
• Other diabetic complications, specify the complication, e.g., diabetic coronary artery disease (CAD) or diabetic hyperlipidemia |
| Treatment:       | Insulin use and/or oral antidiabetic of hypoglycemic drugs |
| Diabetes documented as “out of control” or “poorly controlled” codes to diabetes by type, with hyperglycemia E11.65 (type 2) |
EHR Diagnosis Tracking/Reporting

• Does the electronic health record (EHR) system support/track all diagnosis codes documented?
  - It is critical to report all diagnosis codes related to each member’s visit.

• Some questions to ask your vendor:
  - How many diagnosis codes can the software application accommodate?
  - If 10 or 15 diagnosis codes are documented, can the software application submit all codes for billing or encounter reporting purposes?
  - If the system cannot accommodate all codes, can it be enhanced to track all diagnosis codes documented?
    ▪ Will there be additional costs to accommodate these changes?

• It is critical to report all diagnosis codes identified regardless of system limitations.
Claim/Encounter Submission Issues

• The claim/encounter submitted to the plan does not reflect all diagnosis codes on the medical chart.

• Most common errors:
  ➢ Code submitted is at a higher level than documented
  ➢ Submitted only four (4) diagnosis codes when additional were documented
  ➢ Utilizing outdated super-bill
  ➢ Diagnosis codes submitted for claim/encounter are not documented for that visit/date of service (DOS).
    ▪ Copy/paste function used in electronic health record (EHR) vs. new documentation for DOS
Purpose of CMS RADV audit:

- Confirms documentation substantiates diagnosis codes reported to ensure risk adjustment payment integrity and accuracy.
- CMS clinical auditors validate diagnoses codes reported to ensure the medical record documentation is accurate.
- CMS can and will recoup payment from the plan if chart documentation does not support diagnosis codes reported.
RADV Chart Review/Audit Finding

- Common coding errors found in chart review:
  - Current cancer vs. history of cancer
  - Acute stroke codes; cerebral vascular accident (CVA) vs. history of CVA/late effects
  - Coding (active) sepsis, or acute respiratory failure during a outpatient provider office visit
Clinical/Business/Coding Relationships

• The role of the clinician is to document as accurately as possible the nature of the patient conditions and services done to maintain or improve those conditions.
• The role of the coding professional is to assure that coding is consistent with the documentation.
• The role of the practice manager is to assure that all billing is accurately coded and supported by the documented facts.
CalOptima Coding Tips

• Available on the CalOptima website
• https://www.caloptima.org/en/Providers/ManualsPoliciesAndResources/ProviderTrainings/CodingTips.aspx

Coding and Documentation Tips for Peripheral Vascular Disease

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral arterial disease, intermittent claudication and peripheral vascular disease are all coded to.</td>
<td>173.9</td>
</tr>
<tr>
<td>Atherosclerosis of native arteries of extremities.</td>
<td>170.20-</td>
</tr>
<tr>
<td>Atherosclerosis of the native arteries of extremities with intermittent claudication.</td>
<td>170.21-</td>
</tr>
<tr>
<td>Atherosclerosis of native arteries with rest pain.</td>
<td>170.22-</td>
</tr>
<tr>
<td>Atherosclerosis of native arteries of right leg with ulceration.</td>
<td>170.23-</td>
</tr>
<tr>
<td>Atherosclerosis of native arteries of left leg with ulceration.</td>
<td>170.24-</td>
</tr>
<tr>
<td>Atherosclerosis of native arteries of other extremities with ulcerations — include code to identify the severity of the ulcer (e.g., 98.49a).</td>
<td>170.25-</td>
</tr>
<tr>
<td>Right leg, left leg, bilateral.</td>
<td></td>
</tr>
</tbody>
</table>

Coding and Documentation Tips for Chronic Kidney Disease (CKD)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Severity</th>
<th>GFR value</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Normal or mildly elevated GFR</td>
<td>GFR ≥ 90 ml/min/1.73 m² with kidney damage</td>
<td>N18.1</td>
</tr>
<tr>
<td>Stage II</td>
<td>Mild</td>
<td>GFR 60–89 ml/min/1.73 m² with kidney damage</td>
<td>N18.2</td>
</tr>
<tr>
<td>Stage III</td>
<td>Moderate</td>
<td>GFR 30–59 ml/min/1.73 m²</td>
<td>N18.3</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Severe</td>
<td>GFR 15–29 ml/min/1.73 m²</td>
<td>N18.4</td>
</tr>
<tr>
<td>Stage V</td>
<td>Kidney failure</td>
<td>GFR &lt; 15 ml/min/1.73 m²</td>
<td>N18.5</td>
</tr>
<tr>
<td>ESRD</td>
<td>End stage renal disease</td>
<td>Requiring chronic dialysis/kidney transplant</td>
<td>N18.6</td>
</tr>
<tr>
<td>CKD unspec.</td>
<td>Unspecified</td>
<td>Chronic kidney disease, unspecified</td>
<td>N18.9</td>
</tr>
<tr>
<td>Dialysis status</td>
<td>Stage V or ESRD requiring dialysis</td>
<td>Patient's noncompliance with renal dialysis</td>
<td>299.2</td>
</tr>
</tbody>
</table>

Note: Always use the clinical indicators (GFR values above) to identify and document the stage of the CKD.
Resources

• Medicare Advantage Risk Adjustment general information at the CMS website:
  ➢ https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtsgSpecRateStats/Risk-Adjustors.html

• Questions or for further HCC guidance and education, please email: HCCTeam@caloptima.org
Grievance and Appeals Department

CCN Lunch & Learn
April 18, 2017

Sandra Friend, RN
Manager, Grievance and Appeals

Ana Aranda
Manager, Grievance and Appeals
Common Complaints From Members

- Appointment availability
- Delay in referrals
- No notification of the approved authorization to members
**Tips and Recommendations**

- Inquire about reason for appointment and determine if next available appointment is appropriate.
- Ensure communication is given to the member about their referral status. Educate member about the referral process.
- Notify members of authorization approvals in a timely manner. Have a tracking system of all referrals submitted and communicate to members timely.

**REMINDER:**

- Authorization requests with complete information are processed within five working days and up to 14 calendar days, if additional information is needed.
Common Appeals From Providers

• Level of payment
• Lack of authorization
• Units exceed authorization
Tips and Recommendations

• Understand the terms of your contract.
• Check the CalOptima website for updates to the authorization requirements for CCN providers.
• Check the authorization list prior to submitting a claim for payment to ensure it does not require an authorization.
• Ensure that the claim matches the authorization for procedure codes and units.
Reasons for Denials

• Denials for Medical Necessity
• Denials for Untimely Filing
Tips and Recommendations

- Authorization request should include complete clinical documentation to avoid a denial. Documentation needs to support medical necessity based on criteria.
- Review documentation for legibility prior to submitting the information to CalOptima.
- Please remember to submit your appeals for medical necessity within 90 calendar days from the Notice of Action (NOA). Effective July 1, 2017, the timeline will change to 60 calendar days from the NOA.
- Retro authorization request is limited to specific circumstances and must be requested within 60 calendar days from the initial date of service.
Opioid Update

CCN Lunch & Learn
April 18, 2017

Richard Bock, M.D.
Deputy Chief Medical Officer
Start of Epidemic


* Per 100,000 population.
National Overdose Deaths
Number of Deaths from Opioid Drugs

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths from Heroin

Source: National Center for Health Statistics, CDC Wonder
Changing Face of Opioid Epidemic

Prescription Opioid Overdose Related Deaths 2011 to 2014

- Oxycodone
- Hydrocodone
- Fentanyl

Deaths

2011 2012 2013 2014
Changing Face of Opioid Epidemic

• Prescriptions for OxyContin have fallen nearly 40 percent since 2010, meaning billions in lost revenue for its Connecticut manufacturer, Purdue Pharmaceuticals

• Taking a page from Big Tobacco, OxyContin goes global
  ➢ “We’re only just getting started.”

• A network of international companies owned by the family is moving rapidly into Latin America, Asia, the Middle East, Africa and other regions, and pushing for broad use of painkillers
• Fentanyl-related overdoses prompt CDC alert
  ➢ Wall Street Journal Headline: “Trial Reveals Deep Ties Between Pair of Doctors and Fentanyl Maker: Prosecutors allege two doctors made $40 million in illicit profit”

• DEA issues nationwide warning on Carfentanil
  ➢ Animal opioid sedative, 10,000 times stronger than morphine

• Fentanyl and Carfentanil have been mixed with powder heroin and substituted for pill ingredients

• Combined Benzodiazepine use was associated with 30.1 percent of opioid overdose deaths

• Opioid use was associated with 77.2 percent of benzodiazepine overdose deaths
National Actions to Address Epidemic

• **New Jersey**: Mandated coverage for treatment (6 month in and outpatient)
  - A 5-day cap on the first opioid prescription
  - Opioid education requirements for every licensed health care professional

• **Ohio**: Physicians and dentists can only prescribe up to 50 mg morphine equivalent dose (MED) per day and no more than a 3-day supply

• **California**: Proposal to impose a tax on opioids to fund prevention and rehabilitation services; prohibit opioid prescriptions to minors
National Actions (Cont.)

• **Massachusetts**: Mandatory Prescription Monitoring Program (PMP) database; schools must annually conduct verbal substance misuse screenings; and increased use of specialty drug courts

• **New York**: Requires mandatory prescriber education; no prior authorization allowed for inpatient treatment

• **Repeal and Replace**: Beginning in 2020, the plan would eliminate an Affordable Care Act requirement that Medicaid cover basic mental health and addiction services in states that expanded it
National Actions (Cont.)

• Trump convenes opioid abuse panel with Christie at helm
Opioid Use Disorder Treatment

- Medication-assisted treatment, e.g., Buprenorphine (Suboxone)
  - Stabilizes neurochemical imbalances
  - Relieves symptoms of abstinence syndromes
  - Prevents intoxication and overdose
  - Reduces benzodiazepines

- Overdose rescue — Naloxone

- No wrong door for starting treatment of opioid agonist

- Wellness model with treatment for stable patients located at medical home

- Behavioral restructuring

- Integrated care for needle-related chronic illness, such as HIV and Hepatitis C
CalOptima and HCA SUD Coordinated Services

CalOptima & HCA SUD Coordinated Services Flow Chart

- **CALOPTIMA & PROVIDER NETWORK REFERRAL AND LINKAGE** *
  - 24-HOUR ACCESS LINE
  - OC LINKS
  - ACUTE CARE HOSPITAL VID

- **HCA & PROVIDER NETWORK**
  - INTENSIVE INPATIENT DETOX
  - RESIDENTIAL DETOX
  - RESIDENTIAL
  - INTENSIVE OUTPATIENT
  - OUTPATIENT
  - OPIOID TXT (METHADONE/MAT)

- **CALOPTIMA & PROVIDER NETWORK**
  - PHYSICAL HEALTH CARE SERVICES
  - MEDICATION ASSISTED TREATMENT (MAT)

* Based Upon Screening, Brief Interventions, Referral to Tx (SBIRT)

*Case Management, Physician Consultation and Recovery Support Services are available in all program
CalOptima Interventions – I

• Formulary restrictions January 1, 2017
  ➢ Cumulative morphine equivalent dose (MED) pharmacy edits (Part D)
  ➢ Restrictions for drugs with the highest risk of overdose
    ▪ Methadone
    ▪ Extended-release opioids
    ▪ Concurrent use of opioids and buprenorphine pharmacy edits
CalOptima Interventions – II

• Member restriction programs
  ➢ Pharmacy Home Program Policy (1,022 members enrolled)
  ➢ Prescriber Restriction Program Policy (364 eligible Medi-Cal members, 40 enrolled)
  ➢ Part D opioid overutilization monitoring and case management (60 member interventions)
  ➢ Fraud and abuse referrals to Compliance (176 members)
CalOptima Interventions – III

• Prescriber outreach programs
  ➢ Opioid-containing cough medicines
    ▪ 177 resident reviews
    ▪ 101 discontinued
  ➢ Highest MED prescribers
    ▪ 15 prescribers, 177 high-dose Rx
    ▪ 237 concomitant benzodiazepines
  ➢ High volume/high MED prescribers
    ▪ Top 5 percent sent scorecards (December 2016)
CalOptima Interventions – IV

• Quality measures
  - Retrospective review of opioid overutilization by medical director
    ▪ 120 members referred to Compliance and/or Case Management
  - ACAP plan opioid utilization benchmarking study (on legal hold)
  - Pharmacy Quality Alliance (PQA) Part D Star display measures
    ▪ High dosage
    ▪ Multiple providers
Opioid – High Dosage Measure Performance

![Graph showing Opioid - High Dosage Measure Performance from April 2016 to February 2017. The graph compares MA-PD Average and H8016.](image-url)
OneCare Connect Part D Report Card – Display

Opioid – Multiple Providers Measure Performance
CalOptima Interventions – V

• Ongoing CME series for physicians
  - January 27, 2016
    The State of Opioid Prescribing in Orange County: Practical Strategies and Update on CURES 2.0
    Total attendees: 63
  - July 28, 2016
    The State of Opioid Prescribing in Orange County: Critical Issues in Over-the-Counter (OTC) Analgesia
    Total attendees: 72
  - March 30, 2017
    The State of Opioid Prescribing in Orange County: PCP Treatment Options and Access to Behavioral Health Services

• Informational Series for the community
  - March 3, 2017
    Panel: Drs. Khatibi, Bock and Chakravarthy, and Sandra Fair
CalOptima Interventions – VI

• Coalition participation
  ➢ ACAP
    ▪ Opioid Intervention (2015) – CalOptima cited as one of 13 Best Practice Plans for Pharmacy Lock-in Program
  ➢ Safe Rx OC
    ▪ Since 2015, CalOptima participating with public health agencies, hospitals, prescribers, community clinics, emergency rooms, medical associations and law enforcement to curb abuse and save lives
  ➢ DHCS Health Homes Program (2018)
    ▪ Care management for those with SUD and eligible chronic conditions
Affiliations and Resources

• NIH: National Institute on Drug Abuse
• Drugabuse.gov
• SAMHSA: Substance Abuse and Mental Health Services Administration
• ACAP: SUD Collaborative
• Cures 2.0
• CHCF: Opioid Safety Coalition Network
• Smart Care California (DHCS, CalPERS, Covered CA)
• California Department of Public Health
  ➢ Prescription Opioid Misuse and Overdose Prevention Workgroup
  ➢ Prescription Drug Overdose Prevention Initiative
  ➢ California Opioid Overdose Surveillance Dashboard
Questions
CCN Lunch and Learn Q & A

- Evaluation Form — Please complete and leave behind.

- In your packet, there is a form on which you can write any questions about anything that we have not addressed today.

- What questions do you still have?
CalOptima’s Mission

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