Quality Improvement (Qi) Program Accomplishments and Progress Toward Goals 2018–2019

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QUALITY IMPROVEMENT (QI) PROGRAM ACCOMPLISHMENTS AND PROGRESS TOWARD GOALS 2018–2019

Every year, we share with our members, providers, and community partners the goals of our Quality Improvement (QI) Program. We also share the accomplishments we have made during the past year.

Program Achievement and Outcomes Highlights Include:

▪ In 2019, CalOptima was proud to once again be one of the top-rated Medicaid plans in California according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings 2019–2020.
▪ CalOptima’s Medi-Cal program successfully achieved a commendable accreditation status by NCQA for 2019.

Quality Key Achievements

The Healthcare Effectiveness Data and Information Set (HEDIS) is the nationally recognized tool that we use to measure the clinical quality of health care our members receive. These are high-level results of our HEDIS 2019 (measurement year 2018) efforts:

▪ Medi-Cal: 68 percent of the measures (42 of 62) scored better when compared to previous year.
▪ OneCare: 44 percent of the measures (12 of 27) scored better when compared to previous year.
▪ OneCare Connect: 26 percent of the measures (26 of 43) scored better when compared to previous year.
▪ All clinical measures with a minimum performance level (MPL) set by Department of Health Care Services achieved goal.
▪ The following measures made significant improvement from the previous year:
  ◦ Children’s Access to Primary Care Practitioners
  ◦ Adult Access to Preventive and Ambulatory Health Services
  ◦ Appropriate Testing for Children with Pharyngitis
  ◦ Appropriate Treatment for Children with Upper Respiratory Infection
  ◦ Antidepressant Medications Management
  ◦ Follow-up After Emergency Department Visit for Mental Illness
  ◦ Pain Screening in Older Adults
  ◦ Medication Reconciliation Post-Discharge

Annually, CalOptima also measures our members’ satisfaction with their experience with CalOptima. These are high-level results of our adult and child member experience surveys (measurement year 2018):

▪ The following areas made improvements from the previous year:
  ◦ Rating of Personal Doctor
  ◦ Rating of Specialist
  ◦ Getting Care Quickly
Program Activities Include:

Healthy Community
CalOptima is building a healthy community for our members through our Quality Improvement Projects (QIP). In 2018–2019, improvement projects focused on enhancing or improving:

- Promotion of effective management of chronic disease: Diabetes HbA1C Testing
- Diabetes care for members with poor control (HbA1C >9 percent)
- Adults’ access to preventive/ambulatory health services (AAP)
- The number of members with a completed individualized care plan and documented discussions of care goals
- Control of blood pressure
- Prevention of unplanned hospital readmissions
- Reduction of avoidable hospitalization and other adverse events for nursing facility residents

Member Satisfaction
CalOptima measures quality and service to our members in many ways, including:

- Issuing an annual survey for our members to rate their satisfaction with several important areas like getting needed care, getting care quickly, how well doctors communicate and rating of health plan
- Monitoring and acting on quality of care complaints and grievances
- Monitoring and acting on any identified issues with calls into our customer service center
- Reviewing member satisfaction survey results alongside potential quality of care complaints and grievances, as well as member call center data to identify any provider patterns that require intervention or corrective action
- Hosting monthly team meetings to review data reflective of member experience pain points and act to address them to improve the member experience

To improve member experience, CalOptima has launched a provider coaching pilot that includes:

- Physician shadow coaching
- Physician, manager and staff workshops and trainings to improve customer service
- Physician-patient communication online training for physicians

Access to Care
CalOptima is working to improve access for members by:

- Regularly monitoring our provider network to assure that our members have access to care and services
- Working with our contracted health networks to ensure that there is an adequate network of providers with an appropriate panel size
- Monitoring our providers through a mystery shopper call to assure our members can obtain timely appointments
- Collaborating with providers to host CalOptima Days, a health and wellness event targeting well-care visits and immunizations for children and teens
- Developing provider incentives and new programs to expand access to care

These activities reflect CalOptima’s commitment to the quality of care that our members receive from our provider partners. 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.
Quality Health Care Delivery System

Our action plan to produce a quality health care delivery system is to engage and support providers in the provision of quality health care services for our members. In 2018–2019, CalOptima worked in collaboration with our contracted health networks and providers to improve the following children and women’s health measures:

- Prenatal and Postpartum Visit
- Cervical Cancer Screening
- Breast Cancer Screening
- Childhood and Adolescent Immunizations and Well-Care Visits

Additionally, we collaborate with providers and members to educate them in the appropriate use of antibiotics when the diagnosis is bronchitis.

Program Goals for 2019–2020:

- To maintain the top-rated Medicaid plan in California according to the NCQA Medicaid Health Insurance Plan Ratings
- To attain a 4.5 health plan rating according to the NCQA Medicaid Health Insurance Plan Ratings by 2021
- To maintain accreditation status by NCQA in 2020
- To continue to be recognized by the Department of Health Care Services for “Outstanding Performance 2019” for a large-scale plan
- To attain a 3.0 consumer satisfaction score, according to the NCQA Medicaid Health Insurance Plan Ratings in 2020

If you would like a hard copy of the QI Program and Progress in Meeting Goals, call CalOptima’s Customer Service department at 1-714-246-8500 or toll-free at 1-888-587-8088. TTY users can call toll-free at 1-800-735-2929.

CALOPTIMA’S WEBSITE GETS NEW LOOK AND SELF-SERVICE MEMBER PORTAL

CalOptima recently launched our new member portal. The member portal is a secure online website that gives members 24-hour access to health information.

CalOptima’s new member portal can be accessed in English on a computer, tablet or smart phone device. Additional languages will begin rolling out in fall 2019.

The new self-service options make it easier and faster for members to:

- Update personal information
- Request a new ID card
- Print a copy of ID card
- Change health network or primary care provider (PCP)
- Ask CalOptima Customer Service a question

Complete Annual Health Assessment Survey

Help our members take an active role in their health care. Register at https://member.caloptima.org today!

To make changes online, go to the member portal on the CalOptima homepage at www.caloptima.org.
UNDERSTANDING MEDICAID BENEFITS AND SERVICES

As our look back period rapidly approaches, we are reminded of NCQA’s Medicaid Benefits and Services Standard. The 2015 standard covers the following elements, along with explanation of what will be expected to be reflected in your policy and procedures:

**Direct Access to Women’s Health Services**

Women are allowed direct access to in-network women’s health specialties for covered routine and preventive health care services. Medicaid law requires that women be allowed direct access to women’s health specialists for routine and preventive health care services. Routine and preventive health care services include, but are not limited to, prenatal care, breast exams, mammograms and Pap tests. Direct access means that the organization cannot require women to obtain a referral or prior authorization as a condition to receiving such services from specialists in the network. Direct access does not prevent the organization from requesting or requiring notification from the practitioner for data collection purposes. Women's health specialists include, but are not limited to, obstetricians, gynecologists and certified nurse midwives.

**Second Opinions**

Provide a second opinion from an in-network provider or arrange for the member to obtain a second opinion outside the network. Medicaid law requires that members have the right to a second opinion from a qualified health care professional. If an appropriate professional is not available in network, the organization must arrange for a member to obtain the second opinion out network at no more cost to the member than if the service was obtained in network.

**Out-of-Network Services**

If unable to provide necessary and covered service to a member in network, the organization must adequately and timely cover the same service out network, for as long as the organization is unable to provide the service.

**Out-of-Network Cost to Member**

If the organization approves a member to go out network because it is unable to provide a necessary and covered service in network, the organization must coordinate payment with the out-of-network practitioner and ensure that the cost to the member is no greater than it would be if the service was furnished in network.

**Hours of Operation Parity**

Medicaid law requires the organization to ensure that network practitioners offer hours of operation that are no less (in number or scope) than the hours of operation offered to non-Medicaid members. If the provider serves only Medicaid recipients, hours offered to Medicaid managed care enrollees must be comparable to those for Medicaid fee-for-service members. All five of these elements will be audited in 2019 as part of CalOptima’s delegation oversight responsibilities.

Please feel to call **714-246-8686** if you have any further questions regarding the NCQA Medicaid Benefits and Services.
ACCESSING INTERPRETER SERVICES

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

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

How to Request Interpreter Services

1. Verify the member’s eligibility and identify if the member is enrolled in a health network, CalOptima Community Network or CalOptima Direct.

2. Determine whether telephonic or face-to-face interpreter service is needed.
   - Telephonic interpreter service is recommended for urgent situations or short and simple conversations. This service is available 24 hours a day, seven days a week.
   - Face-to-face interpreter service, including sign language, is recommended when complicated or extensive explanation of treatment or symptoms is required. This service is available for scheduled medical appointments in an ambulatory setting and requires at least five working days’ advance notice.

3. Please have the following information ready at the time of the request:
   - Member’s name
   - Member’s card identification number
   - Member’s gender
   - Member’s age
   - Date of appointment
   - Time of appointment
   - Language needed
   - Approximate duration
   - Type of visit
   - Name of doctor/facility
   - Address of appointment/location
   - Phone number of appointment/location

4. If the member is in CalOptima Direct or CalOptima Community Network, please call CalOptima’s Customer Service department at 714-246-8500. Prior authorization is not required.

5. If the member is in a health network, please use the following list to contact the member’s health network after verifying eligibility. The member’s health network will work with you and the member to coordinate all interpreter services.
# Health Network Interpreter Services Contact List

<table>
<thead>
<tr>
<th>HEALTH NETWORK</th>
<th>TELEPHONIC INTERPRETER SERVICE CONTACT</th>
<th>FACE-TO-FACE INTERPRETER SERVICE CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADOC Medical Group</td>
<td>844-292-5173</td>
<td>844-292-5173</td>
</tr>
<tr>
<td>Alta Med Health Services</td>
<td>877-462-2582</td>
<td>877-462-2582</td>
</tr>
<tr>
<td>AMVI Care Health Network</td>
<td>866-796-4245</td>
<td>866-796-4245</td>
</tr>
<tr>
<td>Arta Western Health Network</td>
<td>800-788-8879 or via fax referral request: 949-567-0236 or via online referral request: <a href="http://www.hcp-connect.com">www.hcp-connect.com</a></td>
<td>800-788-8879 or via fax referral request: 949-567-0236 or via online referral request: <a href="http://www.hcp-connect.com">www.hcp-connect.com</a></td>
</tr>
<tr>
<td>CHOC Health Alliance</td>
<td>800-424-2462</td>
<td>800-424-2462</td>
</tr>
<tr>
<td>Family Choice Health Network</td>
<td>Language line: 800-874-9426</td>
<td>800-611-0111</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>800-464-4000 or 800-777-1370 (TDD/TTY)</td>
<td>800-464-4000 or 800-777-1370 (TDD/TTY)</td>
</tr>
<tr>
<td>Monarch Family HealthCare</td>
<td>888-656-7523</td>
<td>888-656-7523</td>
</tr>
<tr>
<td>Noble Mid-Orange County</td>
<td>888-880-8811 Ask for Utilization Department</td>
<td>888-880-8811</td>
</tr>
<tr>
<td>Prospect Medical Group</td>
<td>800-708-3230</td>
<td>800-708-3230 or fax request to: 714-560-7305 or submit request online: <a href="http://www.prospectmedical.com">www.prospectmedical.com</a></td>
</tr>
<tr>
<td>Regal Medical Group</td>
<td>844-292-5173</td>
<td>844-292-5173</td>
</tr>
<tr>
<td>Talbert Medical Group</td>
<td>800-297-6249 or via fax referral request: 714-436-4408 or via online referral request: <a href="http://www.HCP-Connect.com">www.HCP-Connect.com</a> Need access code for interpreter services</td>
<td>800-297-6249 or fax referral request: 714-436-4408 or via online referral request: <a href="http://www.HCP-Connect.com">www.HCP-Connect.com</a></td>
</tr>
<tr>
<td>United Care Medical Network</td>
<td>877-225-6784</td>
<td>877-225-6784</td>
</tr>
</tbody>
</table>

*Source: Section N7 CalOptima 2015 Provider Manual*
FREQUENTLY ASKED QUESTIONS ABOUT UTILIZATION MANAGEMENT (UM) DECISION-MAKING

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

What criteria and/or guidelines are used to make decisions?
We use nationally recognized guidelines, such as Milliman Care Guidelines and guidelines from professional societies like the American Academy of Family Physicians and the American Congress of Obstetricians and Gynecologists, and those developed by the U.S. Preventive Services Task Force (USPSTF). Guidelines and criteria sets are based on sound clinical principles and processes. They are reviewed and updated as required on an annual basis. To ensure consistency with current standards of care and local practice, we involve actively participating practitioners in the development and approval of criteria.

How can I obtain a copy of the criteria not specifically related to a decision?
As a CalOptima provider, you may request a copy of a specific guideline used by CalOptima that is not related to a UM decision. You can reach the UM staff by calling CalOptima’s Care Coordination department at 714-246-8686 or fax your request to 714-246-8579.

How can I obtain a copy of the criteria used in making a decision?
As a CalOptima provider, you have the right to ask about our UM decisions. You can contact our medical director in writing or via telephone or facsimile. His or her telephone number is included in the Notice of Action letter you received. Alternatively, you can reach the UM staff by calling CalOptima’s Care Coordination department at 714-246-8686.

What if I have a general question about the UM process?
UM staff is available during CalOptima business hours from 8 a.m. to 5:30 p.m. for inbound calls regarding UM issues. After-hours contact with the UM staff is through the on-call service, which will notify staff to contact you. You can reach the UM staff by calling CalOptima’s Care Coordination department at 714-246-8686.
LEARN ABOUT THE CALOPTIMA APPROVED DRUG LIST AND PHARMACEUTICAL PROCEDURES

CalOptima is dedicated to ensuring that our members get the prescription medications they need. The CalOptima Drug Formulary, or the Approved Drug List and pharmaceutical procedures, are reviewed quarterly in February, May, August and November by the Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is composed of practicing primary care physicians, specialists and pharmacists. The P&T committee evaluates all therapeutic drug categories and selects the most cost-effective agents in each class. In addition, the P&T Committee reviews prior authorization procedures to ensure that medications are used safely in accordance with clinical guidelines and FDA-approved indications. The committee also evaluates new pharmaceutical developments including new drug approvals, new indications, new generics and updates to existing clinical guidelines. You may request a medication be added to the Approved Drug List by submitting an Approved Drug List Addition Request form. This form can be found under the under Medi-Cal and CalOptima Direct Resources of the “Pharmacy Information” section of our website.

The Approved Drug List also includes an explanation of limits or quotas such as age, gender, duration of use or quantity limits; any restrictions and medication preferences; the process for generic substitution; contingent therapy requirements; and step-therapy protocols. CalOptima is a mandatory generic plan. This means that a generic equivalent must be used before a branded agent may be considered. CalOptima does not require therapeutic interchange. The CalOptima Approved Drug List is available on our website at www.caloptima.org and on your smart phone through the Epocrates mobile application. In addition, changes to the Approved Drug List are posted quarterly on our website at www.caloptima.org, under the Formulary Resource of the “Pharmacy Information” section.

Medications that are not listed on the Approved Drug List require prior authorization. Providers may request an authorization by submitting all relevant clinical information to CalOptima. Providers may submit the CalOptima prior authorization form via fax to 858-357-2557, or by calling 888-807-5705. The CalOptima prior authorization form may be found under Medi-Cal and CalOptima Direct Resources in the “Pharmacy Information” section. The Medi-Cal Provider Manual on our website at www.caloptima.org provides more information on how to use the Approved Drug List and how to submit a prior authorization request. If you would like more information about the Approved Drug List, our prior authorization criteria, or the CalOptima pharmacy program, please contact the Pharmacy Management department at 714-246-8471.

The CalOptima Pharmacy Management department and the P&T Committee continually monitor the safety of medications used by our members. In situations when there is a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing practitioners are notified by CalOptima within 30 calendar days of the Food and Drug Administration notification. An expedited process is in place to ensure notification to affected members and prescribing practitioners of Class I recalls as quickly as possible. These notifications will be conducted by fax or mail.
PRIMARY CARE PROVIDER TERMINATION OR CHANGE IN ACCESS: MEMBER NOTIFICATION REQUIREMENT

CalOptima provides the following information as a reminder of existing regulatory and policy requirements. CalOptima’s expectation is that all health networks and providers are currently in compliance. Please note CalOptima may issue corrective action plans for instances of non-compliance.

Department of Health Care Services (DHCS) All-Plan Letter (APL) 16–001: Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertification

Managed care plans (MCPs), like CalOptima, are required to obtain written approval from DHCS prior to making any substantial change in the availability or location of covered services. The protocol for obtaining approval and the beneficiary notification requirements may vary depending on what type of provider is being terminated: 1) subcontracted providers; 2) clinics and primary care providers (PCPs); 3) Independent Physician Groups (IPAs) and medical groups; or 4) hospitals.

For Clinic and PCP Terminations:

▪ At least 60 days prior to the expected date of termination, CalOptima must submit the member notice and a description of how CalOptima intends to continue to provide covered services to impacted members to DHCS for review and approval. Health networks should not mail the member notice to impacted membership until DHCS has approved the narrative and member notice, even if the health network will be utilizing a DHCS approved template.
  ◦ The member notice must be mailed to affected members at least 30 days prior to the expected date of the contract termination with the clinic or PCP. This applies only when the contract termination will result in more than 500 members having to change their PCP (across CalOptima’s entire network), or if there are members who cannot be reassigned within the time and distance standards.
  ◦ In cases where the contract termination will result in less than 500 members having to change PCPs, and all affected members can be reassigned to PCPs within time and distance standards, MCPs may use a boilerplate member notice that was previously approved each time such a termination occurs.

▪ CalOptima’s health networks must provide timely notification to CalOptima when clinic or PCP terminations occur to determine which of the above processes apply and to meet the timelines for notifying DHCS and members, when applicable.

CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services

▪ CalOptima or a health network shall ensure that members are notified in a timely manner of any significant changes in the availability or location of covered services, including:
  ◦ Changes in the hours, days or location at which covered services are available
  ◦ Terminations, suspensions, decertification, or non-renewal of a health network’s or provider’s contract with CalOptima or a health network, including terminations, suspensions and decertification from the Medi-Cal program as effectuated by DHCS.
CalOptima or a health network shall notify members in writing of any significant change in the availability or location of covered services, or any other significant change in information, at least 30 calendar days prior to the effective date of such change, unless otherwise specified.

- CalOptima shall obtain approval from DHCS prior to making any substantial change in the availability or location of covered services, including but not limited to, any proposal to reduce or change the hours, days or location at which the services are available, at least 60 calendar days prior to the expected date of termination. If DHCS does not approve the change, CalOptima or a health network may not implement the change.

- In the event of a natural disaster or emergency, CalOptima or a health network shall notify members of any significant change in the availability or location of covered services as soon as possible, and within 14 calendar days of the change.

- CalOptima’s health networks must provide timely notification to CalOptima when clinic or PCP terminations occur to determine which of the above processes apply and to meet the timelines for notifying DHCS and members, when applicable.

CalOptima’s health networks must ensure members receive timely notification anytime there is a change in the availability or location of covered services as outlined above.

**CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services**

- Health networks shall notify the CalOptima Health Network Relations department of a change in the availability or location of covered services, a termination of a contracted provider, PCP, community health center, contracted health network, IPA, medical group, or contracted hospital contract, or any other significant changes in information at least 90 calendar days prior to the change or termination.

- Concurrently with the member notice, a health network shall submit a description of how the Health Network intends to provide covered services to affected members to CalOptima’s Health Network Relations department for review in advance of change or contract termination for contracted providers, PCPs, community health centers, IPAs, medical group, or hospital terminations following the criteria outlined in APL 16–001.

If you have any questions about the information contained in these references or the requirements highlighted above, please contact the CalOptima Provider Relations department at 714-246-8600.

For your reference, CalOptima’s current policies and procedures can be found on CalOptima’s website ([www.caloptima.org](http://www.caloptima.org)) and notification of any updates to these policies and procedures is communicated monthly via the CalOptima Provider Update Fax Blast.
CALOPTIMA MEETING INFORMATION

Unless otherwise noted, meetings take place in the assembly rooms on the first floor at CalOptima, 505 City Parkway West, in Orange. For more information, please call 714-246-8600.

CalOptima Board of Directors*
2 p.m.
December 5, 2019
January 2020 – No regular meeting scheduled
February 6, 2020
March 5, 2020

CalOptima Board of Directors’ Finance and Audit Committee*
2 p.m.
February 20, 2020

Member Advisory Committee (MAC)*
2:30 p.m.
December 12, 2019
February 13, 2020

OneCare Connect Member Advisory Committee (OCMAC)*
3 p.m.
December 19, 2019
February 27, 2020

Provider Advisory Committee (PAC)*
8 a.m.
December 12, 2019
January 2020 – No regular meeting scheduled
February 13, 2020

Whole-Child Model Family Advisory Committee (OCMAC)*
9:30 a.m.
December 3, 2019
February 25, 2020

*Public meeting

The people in the photographs that appear in this document are models and used for illustrative purposes only.