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

WEDNESDAY, SEPTEMBER 12, 2018
3:30 P.M.

505 CITY PARKWAY WEST, SUITE, 109-N
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
Paul Yost, M.D., Chair
Ria Berger
Dr. Nikan Khatibi
Alexander Nguyen, M.D.

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Suzanne Turf

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

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 May 16, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
2. Consider Recommending Board of Directors' Approval of the Updated Strategy for the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to CalOptima Community Network

INFORMATION ITEMS

3. PACE Member Advisory Committee Update

4. CalOptima Personal Care Coordinator Evaluation

5. 2018 National Committee for Quality Assurance (NCQA) Update

6. Healthcare Effectiveness Data and Information Set (HEDIS) 2018 Results

7. Member Experience Initiatives Update

8. Whole-Child Model Update

9. Bright Steps Perinatal Support Program

10. Depression Screening Initiative Update

11. Health Homes Program Update

12. Quarterly Reports to the Board of Directors' Quality Assurance Committee
    a. Quality Improvement Committee – First and Second Quarter 2018 Update
    b. Member Trend Report – First Quarter 2018 Update

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 16, 2018

CALL TO ORDER

Acting Chair Ria Berger called the meeting to order at 3:00 p.m. Director Khatibi led the pledge of Allegiance.

Members Present: Ria Berger, Acting Chair; Dr. Nikan Khatibi; Alexander Nguyen, M.D.

Members Absent: Paul Yost, M.D., Chair

Others Present: Michael Schrader, Chief Executive Officer; Richard Helmer M.D., Chief Medical Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Diana Hoffman, Deputy Chief Counsel; Ladan Khamseh, Chief Operating Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the February 20, 2018 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the February 20, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Chair Yost absent)***

Acting Chair Berger reordered the agenda to hear Item 5, PACE Member Advisory Committee Update.

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5. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on the activities at the March 26, 2018 PMAC meeting, including a presentation of the 2017 Participant Satisfaction Survey results. The Committee was also informed of the upcoming changes to the number and type of vehicles used for participant transport, and that those impacted by the change will be notified in advance.

REPORTS

2. Receive and File 2017 Utilization Management Program Evaluation

Action: ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the 2017 Utilization Management Program Evaluation as presented. (Motion carried 3-0-0; Chair Yost absent)***

3. Consider Recommending Board of Directors' Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment of Participating Health Networks

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors' approval of the methodology for and the disbursement strategy of OneCare Connect demonstration years 2-5 (calendar years 2016-19) quality withhold payment to contracted health networks, including the CalOptima Community Network (CCN).

Dr. Bock reported that the Cal MediConnect quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. CalOptima can earn back withheld funds by CalOptima by passing a percentage of defined quality withhold measures prescribed by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) based on industry standard quality metrics. It was noted that while the CalOptima's health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for, and other measures that have shared responsibility between the delegated health networks and CalOptima. The proposed methodology to distribute earned withhold funds back to contracted health networks was presented to the Committee for discussion.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors' approval of the methodology for and the disbursement strategy of OneCare Connect demonstration years 2-5 (calendar years 2016-19) Quality Withhold payment to contracted Health Networks, including CalOptima's Community Network. (Motion carried 3-0-0; Chair Yost absent)***

4. Consider Recommending Board of Directors' Approval of the Modification of the Previously Approved Pay for Value Payment Methodology for Measurement Year (MY) 2017 for CalOptima Community Network (CCN) Providers by Incorporating an Improvement Factor

Dr. Bock presented the action to recommend Board of Directors' approval of the addition of an improvement factor to the MY2017 payment methodology for CCN primary care providers for Medi-Cal, subject to regulatory approval, as applicable. As proposed, the addition of an improvement

factor for the CCN Pay for Value (P4V) program aligns the health network and CCN P4V programs. This alignment will leverage improvement efforts and efficiencies that CCN implements in conjunction with the other Health Networks. A review of the incentive payment methodology was provided to the Committee.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the addition of an improvement factor to the MY2017 payment methodology for CCN primary care providers for Medi-Cal, subject to regulatory approval, as applicable. (Motion carried 3-0-0; Chair Yost absent)***

INFORMATION ITEMS

6. PACE Primary Care Physician Incentive Program Update

Miles Masatsugu, M.D., PACE Clinic Medical Director, presented an overview of the proposed modifications to the PACE Primary Care Physician (PCP) Incentive program, including: allowing all PACE PCPs and community-based physicians to participate in the PACE incentive program; increasing the number of quality improvement (QI) elements to align with other lines of business; increasing the QI incentive from $3 per member per month (PMPM) to $10 PMPM; and change the distribution of utilization management (UM) inpatient cost savings sharing element to support inpatient avoidance strategies, including after-hours telephonic coordination of care, after-hours home visit evaluations, admissions directly to senior nursing facilities for appropriate cases, and emergency room evaluations with observation stays. Dr. Masatsugu reviewed the proposed QI incentive elements and proposed UM incentive for discussion.

7. Perinatal Support Services Update

Dr. Bock provided an update on the Perinatal Support Services (PSS) program. In April 2018, a Request for Information/Request for Proposal process was conducted. Two qualified respondents were identified to provide perinatal support services for CalOptima members. One of the responders bid below the Medi-Cal Comprehensive Perinatal Support Program (CPSP) fee-for-service rates. The other respondent, the current capitated vendor, provides PSS services through home visits. However, this vendor's proposed compensation was significantly higher than what would be reimbursed based on the Medi-Cal CPSP fee-for-service rates. It was reported that staff also reviewed current County PSS providers/vendors and rate data, and confirmed that there are over 250 independent, certified CPSP providers currently serving CalOptima members at the CalOptima Medi-Cal fee-for-service rates. Staff proposed the following recommendations for consideration by the Board of Directors at the June meeting: withdraw the Perinatal Support Services RFP; authorize CalOptima to contract with all willing, qualified PSS providers and vendors at Medi-Cal rates; and authorize the addition of an enhanced care coordination rate to compensate for authorized home visits.

8. Quarterly Reports to the Board of Directors' Quality Assurance Committee

The following Quarterly Reports were accepted as presented:

a. Quality Improvement Committee First Quarter 2018 Update
b. Member Trend Report – Fourth Quarter 2017

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COMMITTEE MEMBER COMMENTS

Committee members commented on the importance of ensuring member access to quality health care and member satisfaction.

ADJOURNMENT

Hearing no further business, Acting Chair Berger adjourned the meeting at 4:03 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 12, 2018

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 12, 2018
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

2. Consider Recommending Board of Directors' Approval of the Updated Strategy for the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to CalOptima Community Network (CCN)

Contact

Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Approve the updated strategy for the disbursement of One Care Connect (OCC) demonstration years (DY) 2-5 (calendar years 2016 – 19), quality withhold payment to CalOptima's Community Network (CCN).

Background

OneCare Connect (OCC) is a Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. 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 often 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 to members, OCC adds benefits such as vision care, gym benefits and enhanced dental benefits. 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.

To better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. Medi-Cal monies are not withheld from health networks. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Four, and Five (calendar years 2017-2019). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received by CalOptima Regulatory Affairs from CMS and DHCS.

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On August 6, 2015, the CalOptima Board of Directors approved the methodology and disbursement of the DY 1 (Measurement Year [MY] 2015) quality withhold that was received from DHCS and CMS in October 2017 and distributed to the health networks. On June 7, 2018, the CalOptima Board of Directors approved the methodology and disbursement of earned quality withhold dollars for DY2-5 to health networks.

Discussion

CalOptima began to participate in the Cal MediConnect program on July 1, 2015. Because CalOptima's participation in Cal MediConnect began midyear, the measurement period for DY 1 was considered July 1, 2015 to December 31, 2015. Subsequent years (years 2-5) began in 2016 and reflect services rendered from January 1 to December 31 of each year.

The quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. These withheld funds can be earned back by CalOptima by "passing" a percentage of defined quality withhold measures. Measures are "passed" by managed care plans by achieving the established benchmark set by CMS for each quality withhold measure. The measures are prescribed by DHCS and CMS based on industry standard quality metrics such as HEDIS/Star measures and are communicated to plans via the Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes. Managed care plans earn their withhold back according to the following guidance:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

The health networks do not have full accountability for every measure. There are measures that CalOptima has direct responsibility for, and others that have shared responsibility between the delegated health networks and CalOptima.

On June 7, 2018, the CalOptima Board of Directors approved the methodology and disbursement of earned quality withhold dollars for DY2-5 to health networks. Unlike participating health networks, CCN providers are paid at Fee-for-service rates without any quality withholds. In addition, CCN providers are part of the Pay for Value program, wherein they receive incentives for performing on selected clinical and member satisfaction measures. After further review of the program, staff is proposing that there is no need for a distribution strategy for CCN providers as there was no money withheld from the CCN providers.

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Fiscal Impact

The recommended action to approve the updated strategy for the disbursement of OCC DY 2-5 (calendar years 2016-19), Quality Withhold payment to CCN providers will have no additional fiscal impact to CalOptima. There will be no additional disbursement of funds to CCN providers.

Rationale for Recommendation

These recommendations reflect alignment between CalOptima Community Network providers and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount. However, since no funds were ever withheld from CCN providers, there is no basis for distributing withhold funds earned back to those providers.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 6, 2015, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks
2. Board Action dated June 7, 2018, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

/s/ Michael Schrader — *09/05/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. F. Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact
Richard Bock, MD, Deputy Chief Medical Officer, (714) 246-8400

Recommended Action
Approve the methodology for and the disbursement of the Year One, OneCare Connect Quality Withhold payment to participating Health Networks.

Background
July 2012 marked the passage of the Coordinated Care Initiative in California. The Coordinated Care Initiative (CCI) aims to integrate the delivery of medical, behavioral, and long term care services while providing a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" members.

Central to the CCI model is care coordination. And a critical piece to the model is the care coordination provided for by the member's primary care provider (PCP) and health network. The CCI is expected to produce greater value by improving health outcomes and containing costs; primarily by shifting clinically appropriate service delivery into the home and community and away from expensive institutional settings.

In order to better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. The amounts of the withhold are 1% for Year One, 2% for Year Two, and 3% for Year Three. All or a part of the withhold may be earned back based on a methodology developed by DHCS and CMS.

Discussion
CalOptima began to participate in the CCI program on July 1, 2015. Given the delayed start date of the program, the first year of the withhold process will be shortened to reflect services rendered from July 1, 2015 to December 30, 2015.

There are ten quality withhold measures in CCI for Year one. Five of these measures are California-specific and were just released by CMS on July 8, 2015.

- Encounter data
- Getting appointments and care quickly
- Customer service
- Behavioral Health provider participates in care plan development (shared accountability measure, payout shared with county)

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- Documentation of care goals
- Case Management contact with member
- OneCare Connect Member Advisory Council implementation
- Memorandum of understanding with County Mental Health
- Timely completion of Health Risk Assessments
- Physical access work plan

Capitation for both Medi-Cal and Medicare payments to CalOptima will be reduced by one percent (1%) in Year One. These withheld funds can be earned back by CalOptima in the following manner:

- Plan will pass or fail each measure based on benchmarks
- All withhold measures will be weighted equally
- If a measure cannot be calculated due to timing constraints (of the shortened Year one) or enrollment requirements, it will be removed from the total number of withhold measures on which the plan will be evaluated.
- Payout will be based on:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

Distribution of Earned Withhold Funds to the Health Networks:
CalOptima's contracts with the networks provides that "CalOptima will allocate to Physician Group, and amout of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval." While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima. In addition, since the two Behavioral Health measures are governed by language in the three-way contract regarding shared responsibility with County Mental Health, disbursement for them will be described in a future staff recommendation to the Board after further guidance from the State is released. Similarly, distribution of earned back withhold funds attributable to Community Network membership will be described in a future staff recommendation. As 1% of capitation is withheld from CalOptima, the downstream percent of premium (POP) Medicare capitation payments to Health Networks will be similarly reduced. Taking into consideration the truncated duration of Year One and continuing regulatory refinement of the program, the methodology that staff is proposing for Year One provides that Medicare withhold funds which are earned back by CalOptima will be shared with the Health Networks using the identical POP formula.

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- For example, if CalOptima's revenue is $1,000 per member per month (PMPM), the quality withhold is 1%, and a networks's POP is 35%, the network's capitation will be 35% x $990, which is $346.50 PMPM.

- Assuming CalOptima recoups the full withhold of $10, the network will receive 35%, or $3.50 PMPM.

- Future distribution formulae for Years 2 and 3 may take into account the Health Networks' per cent responsibility for, and the relative performance on, the expanded measure set, but this simpler approach is more appropriate for Year One.

- If CalOptima does not recoup any withhold money, then no Quality Withhold money will be paid out to any network regardless of their performance on the quality measures.

Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period as well as at the time of distribution.

Fiscal Impact
The recommended action is projected to be budget neutral to CalOptima. Distributions to health networks will not exceed the amount of withheld funds that are earned back.

Rationale for Recommendation
These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/31/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve the methodology for and the disbursement strategy of One Care Connect (OCC) demonstration years (DY) 2-5 (calendar years 2016 – 19), Quality Withhold payment to contracted Health Networks, including CalOptima's Community Network (CCN).

Background

OneCare Connect (OCC) is a Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. 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 often 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 to members, OCC adds benefits such as vision care, gym benefits and enhanced dental benefits. 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.

To better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. Medi-Cal monies are not withheld from health networks. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Four, and Five (calendar years 2017-2019). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received by CalOptima Regulatory Affairs from CMS and DHCS.

On August 6, 2015, the CalOptima Board of Directors approved the methodology and disbursement of the DY 1 (MY2015) quality withhold that was received from DHCS and CMS in October 2017 and

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distributed to the health networks. Additional Board action is required for the methodology and distribution of earned quality withhold dollars for DY2-5.

Discussion

CalOptima began to participate in the Cal MediConnect program on July 1, 2015. Because CalOptima's participation in Cal MediConnect began midyear, the measurement period for DY 1 was considered July 1, 2015 to December 31, 2015. Subsequent years (years 2-5) began in 2016 and reflect services rendered from January 1 to December 31 of each year.

The quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. These withheld funds can be earned back by CalOptima by "passing" a percentage of defined quality withhold measures. Measures are "passed" by managed care plans by achieving the established benchmark set by CMS for each quality withhold measure. The measures are prescribed by DHCS and CMS based on industry standard quality metrics such as HEDIS/Star measures and are communicated to plans via the Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes. Managed care plans earn their withhold back according to the following guidance:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima.

CalOptima proposes the following methodology to distribute earned funds back to contracted health networks:

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Health Network Scoring

- Quality Points is the sum of all points earned for each measure.

Health Network Measure Performance Points

- Uses NCQA National Medicaid HEDIS Percentiles as benchmark for NCQA HEDIS measures
- Uses CMS Star Cut Points as Benchmark for CMS Star Measure(s)
- Minimum denominator of 1% of Total Denominator

Quality Points	Star / Percentile
1	3 Stars / 50th Percentile
2	4 Stars / 75th Percentile
3	5 Stars / 90th Percentile

Health Plan Measure Points

- Benchmark is set by Cal MediConnect.
- Points based on CalOptima's rate for measure
  - 1 point if CalOptima passes measure
  - 0 point if CalOptima does not pass measure

Distribution of Earned Withhold Funds to the Health Networks

CalOptima's contracts with the health networks provides that "CalOptima will allocate to Physician Group an amount of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval."

- The methodology that staff is proposing for DY2-5 provides that Medicare withhold funds which are earned back by CalOptima will be distributed to the Health Networks, including the CalOptima Community Network (CCN), based on performance and percent of premium (POP). The distribution to a health network will not exceed the amount of funds originally withheld from its capitation. If CMS does not return withheld funds based on performance results, then no Quality Withhold money will be paid out to any network, regardless of their performance on the quality measures.
- Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period, as well as at the time of distribution.

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- Distribution of earned back withhold funds attributable to CalOptima Community Network (CCN) membership will be similar to other health network distribution of withheld dollars. Staff will return at a later date to propose a distribution strategy specifically to CCN providers.
- Withhold money will be distributed to health networks, including CalOptima Community Network (CCN), after CalOptima receives the withhold money from CMS.
- Health Networks will receive their withhold money within 90 days of CalOptima receiving the withhold money from CMS.
- CalOptima contracts with health networks under various arrangements and the allocation for each health network will depend on the withheld amounts received from CMS and the health network performance on the quality measures benchmarked by CMS.
- Health Network payment will depend on the arrangement with CalOptima. Based on current capitation contract arrangement with health networks for CMS revenue, Health Maintenance Organizations (HMOs) will receive their contractually agreed percentage of the withheld amounts for professional services and for hospital services.
- For Physician Hospital Consortiums (PHCs) however, the Physician side of the PHCs will receive their contractually agreed percentage of the withheld amounts for professional services but CalOptima will pay the contractually agreed percentage for hospital services directly to the hospitals.
- Shared Risk Groups (SRGs) will also receive their contractually agreed percentage of the withheld amounts for professional services but the hospital allocation will be contributed to the SRG pool.

Fiscal Impact

The recommended action is budget neutral to CalOptima. The amount of Medicare quality withhold funds earned back by CalOptima, if any, will be sufficient to fund distributions to health networks and CCN with no additional fiscal impact to the operating budget.

Rationale for Recommendation

These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

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Attachment
Board Action dated August 6, 2015, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

/s/ Michael Schrader *5/30/2018*
Authorized Signature **Date**

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Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting June 18, 2018

- Updates from the Director

    - New staff welcomed to the PACE team include a new Center Manager and Quality Improvement Manager. PACE also welcomes a new Outreach Specialist, Nurse Practitioner and Medical Records Specialist.

- New Items Discussed

    - Dietary Services Focus Group:
        - Dietary Services Supervisor Cyndi Stivers, RD, facilitated a discussion on dietary services at PACE. Members of the committee were asked to participate in a survey regarding experience, satisfaction with meals, and preferences. Committee members were also provided a monthly food calendar and asked to circle their most preferred meal choices and crossed out items they did not particularly enjoy.
        - Member suggestions included:
            - tomato juice to be added to beverage options
            - more sugar in drinks
            - have chips and salsa, olives, or hummus and celery as a snack option
            - having a snack alternative sign in different languages
            - more different types of cheeses such as brie and camembert
            - Greek salads with feta
            - orange flavored water
            - more fish and seafood options
        - General Discussion: One participant likes all the shakes while another doesn't like cheese. One participant likes chia seed pudding. Dietary Services Supervisor reminded members that alternatives are always available and offered during meal service.

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CalOptima PCC Evaluation

Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Tracy Hitzeman, RN, CCM
Executive Director, Clinical Operations

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Overview

- Background and Scope
- Data Analysis
  - Health Network Performance Profiles
  - Cal MediConnect Core Measures
  - Health Effectiveness Data and Information Set (HEDIS)
  - Performance Quality Alliance (PQA) Medication Measures
  - PCC Success Stories
- Summary of Findings
- Recommendations
- Conclusion

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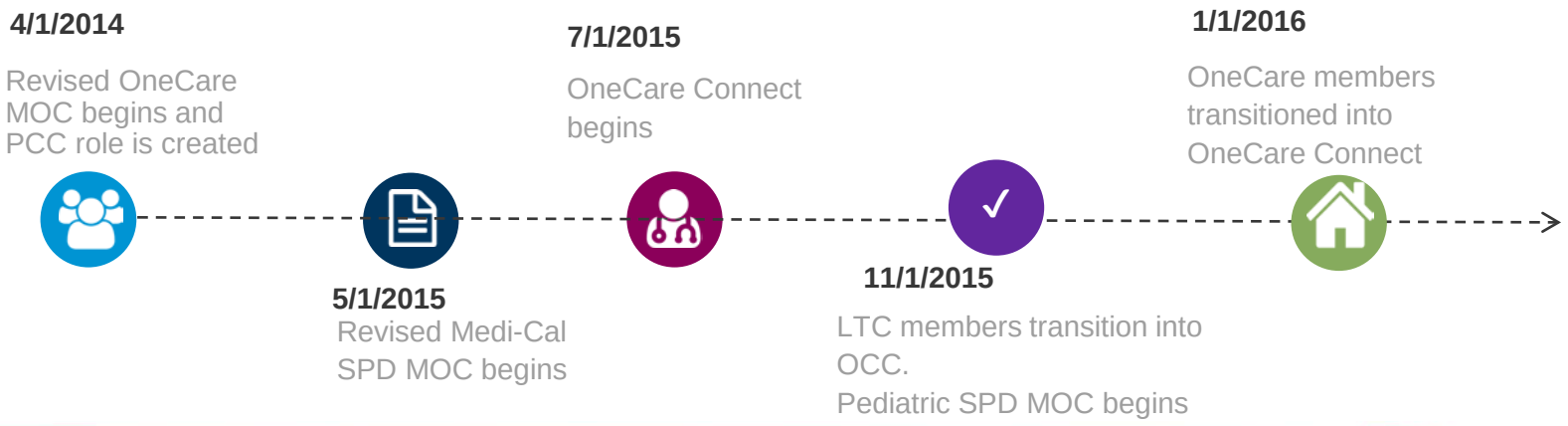
Background and Scope

- The Personal Care Coordinator role was designed to support implementation of the Health Risk Assessment (HRA), Individualized Care Plan (ICP), and the care planning process
  - Beginning in 2014, CalOptima created and implemented the PCC role for the Model of Care
  - The role was introduced to increase CalOptima and Health Network (HN) compliance with CMS care management requirements and improve care coordination and efficiency
  - Additional goals included improving the care experience for members and providers and increasing CalOptima oversight of the Health Networks



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PCC Role and Responsibilities

All OCC, OneCare and SPD members are assigned a PCC

- Primary Care Coordinators:
  - Act as the member's primary point of contact for care management
  - Work closely with member's case management team to resolve access, medical and psychosocial issues, and facilitate care team communication
  - Work with contracted primary care providers (PCPs) to assist members in reaching preventive care goals
  - Monitor and facilitate care interventions and communicate with member, PCP, and case manager
  - Schedule and participate in Interdisciplinary Care Team (ICT) meetings, as needed
  - Facilitate signing and distribution of the Individual Care Plan (ICP) to members of the ICT

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Project Scope

- CalOptima engaged an independent consultant group to conduct an evaluation of the PCC's impact using a combination of quantitative and qualitative data sources

- Evaluation data included both process and outcomes measures and was focused on metrics that the PCC directly or indirectly influences in their role

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Data Analysis

A variety of data sources was reviewed, including both quantitative and qualitative information from 2012-2017:

- **Health Network Status Reports**
- **PCC Success Stories**
- **Cal MediConnect Core Measures**
- **HEDIS**
- **PQA Medication Management Measures**
- **CAHPS Member Satisfaction**
- **PCP Satisfaction Survey**

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Health Network Status Reports

- Steady improvements are seen across the board for measures selected for OneCare

OneCare					
	MOC Network Status Measure	2014 (June-Dec)	2015	2016	2017
1.	Documented Review of HRA/ICP	90.04%	95.95%	99.22%	98.71%
2.	Documentation of Invitation/Inclusion of Member and/or Representative	83.73%	96.73%	96.23%	98.06%
3.	Document of Inclusion/Involvement of Pertinent Specialist or Discipline	63.78%	93.50%	97.21%	98.18%
4.	Addressed All Issues Identified in HRA and ICP Timeframe	85.06%	93.83%	96.41%	99.25%
5.	Evidence That Member Received Final ICP	78.11%	94.25%	97.93%	98.62%

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Health Network Status Reports

- In the OneCare Connect Program, measure 5 demonstrates consistent ability to address all issues raised in the HRA for both new members and those receiving annual re-assessments

OneCare Connect						
MOC Network Status Measure		2015	2016		2017	
		New	New	Annual	New	Annual
1.	Member or Representative Invited or Attended	89.67%	87.53%	96.00%	99.23%	99.48%
2.	PCP Invited or Attended	95.59%	94.52%	100.00 %	99.73%	99.64%
3.	Appropriate Discipline and Specialists Invited or Attended	55.43%	83.88%	93.75%	95.96%	96.08%
4.	ICP Developed Within 30 Days of HRA Completion	77.61%	65.23%	86.00%	93.80%	93.45%
5.	Addressed All Issues in HRA	93.19%	96.82%	100.00 %	99.43%	99.21%
6.	Member Version Provided with Date/Mail Documentation	60.05%	87.73%	92.90%	99.48%	98.98%

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Health Network Status Reports

- Measures selected for the SPD population demonstrate consistent compliance

	SPD			
	MOC Network Status Measure	2015	2016	2017
1.	Member or Representative Invited or Attended	93.35%	98.81%	99.15%
2.	PCP Invited or Attended	95.20%	99.08%	99.30%
3.	Appropriate Discipline and Specialists Invited or Attended	82.12%	95.86%	98.16%
4.	Addressed All Issues in HRA	96.43%	98.48%	99.22%
5.	Member Version Provided with Date/Mail Documentation	83.59%	98.23%	99.45%

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Cal MediConnect Core Measures

OneCare Connect exceeded the average for two measures:

- Percent of members willing to participate and who the MMP was able to locate with an assessment completed within 90 days of enrollment
- Percent of low-risk members with an ICP within 30 working days after the completion of the initial HRA

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Cal MediConnect Core Measures

OneCare Connect was below the average for three measures:

Percentage of members with an ICP

Percentage of members with documented discussion of care goals

Percentage of members who have a care coordinator and at least one care team contact during the reporting period

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OneCare Trended HEDIS Rates

Several HEDIS measures demonstrated steady improvement over the evaluation timeframe*

	OneCare					OneCare Connect
HEDIS Measure	HEDIS 2013	HEDIS 2014	HEDIS 2015	HEDIS 2016	HEDIS 2017	HEDIS 2017
Care for Older Adults (COA)						
Advance Care Planning	35.42%	40.28%	36.57%	53.70%	41.06%	41.20%
Medication Review	77.55%	79.63%	90.74%	86.57%	80.79%	74.54%
Functional Status Assessment	44.44%	39.81%	50.46%	56.94%	57.62%	55.32%
Pain Screening	51.85%	76.16%	87.27%	85.88%	80.13%	78.70%
Adults' Access to Preventive/Ambulatory Health Services (AAP)	92.70%	94.10%	93.95%	93.61%	95.95%	86.91%

Each of the Care for Older Adult sub-measures are assessed during the ICP creation process

*There were multiple interventions to address quality improvement; PCC involvement was one part of the strategy.

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OneCare Connect Comparative HEDIS Rates

- PCC impacts these measures by facilitating preventive care and chronic care management

Measure	OneCare Connect HEDIS 2017	CA Average HEDIS 2017
Adult BMI Assessment	96.06%	92.01%
Breast Cancer Screening	70.33%	62.75%
Colorectal Cancer Screening	62.15%	53.48%
Controlling Blood Pressure	70.00%	63.15%
Beta Blocker Treatment after a Heart Attack	96.97%	85.06%
Diabetes HbA1c Good Control	61.81%	59.44%
Follow-up After Hospitalization for Mental Illness- 30 days	59.35%	46.55%
Adult Access to Preventive Health Services- Total	86.91%	83.43%
Medication Reconciliation	28.30%	32.40%

*There were multiple interventions to address quality improvement; PCC involvement was one part of the strategy.

PQA Medication Management

- OneCare has achieved the highest ranking of five stars in medication adherence for Diabetes and Cholesterol Medications

	2013	2014	2015	2016	2017	2018
High Risk Medications*	2% ★★★★★	1% ★★★★★	7% ★★★★★	5% ★★★★★	4% ★★★★	
Diabetes Treatment	89% ★★★★★	89% ★★★★★	90% ★★★★★			
Medication Adherence for Diabetes Medications	75% ★★★	76% ★★★★	78% ★★★★	78% ★★★★	79% ★★★★	86% ★★★★★
Medication Adherence for Hypertension (RAS antagonists)	75% ★★★	76% ★★★★	78% ★★★	77% ★★★★	78% ★★★	80% ★★★
Medication Adherence for Cholesterol (Statins)	69% ★★★	71% ★★★★	73% ★★★	75% ★★★★	76% ★★★	87% ★★★★★
*lower rate is better						

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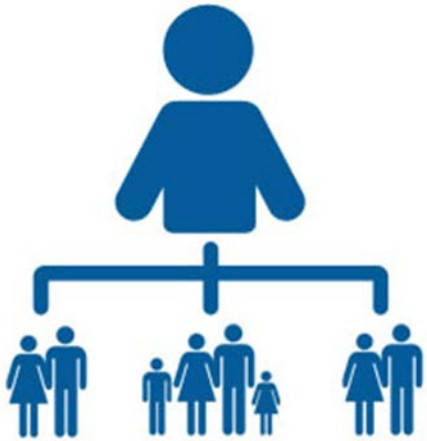
PCC Success Stories

PCCs help patients overcome barriers to accessing care in order to improve health outcomes

- A child member with multiple complex conditions had difficulty obtaining an authorization for hand therapy. An ICT meeting was convened with the member's parent and PCP attending
- Members are a husband, 95 years old, and wife, 91 years old. Both have been accessing the majority of their care at a local urgent care facility
- A child member was exhibiting inappropriate and self-harming behavior. He was receiving speech therapy based on an IEP at school but did not have other treatment
- A 75-year old member was unable to contact and had not seen his assigned PCP. The PCC contacted the member by mail to initiate contact and the member visited the PCC



- The PCC was able to coordinate an authorization for hand therapy and to coordinate medications and orthotic shoes
- The PCC established the same care manager for the couple and ensured that an ICT occurred. The husband was identified as needing a higher level of care such as PACE or IHSS
- The child was able to receive ABA services and was connected with a social skills group. The member has exhibited fewer adverse behaviors and is performing better at school and at home
- The member was hospitalized one time and asked the inpatient nurse to contact his PCC for notification of the admission. The member makes an annual visit to the PCC and his now engaged with his PCP and specialists

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PCC Success Stories (cont'd)

CalOptima PCCs help Members and the Care Team by:

- ☑ Identifying member needs and barriers to accessing care
- ☑ Ensuring that identified needs and goals are addressed at an ICT as appropriate
- ☑ Referring members to community-based resources
- ☑ Coordinating authorizations, referrals to specialists, and treatment
- ☑ Improving access to care and improved member health outcomes
- ☑ Creating and maintaining engagement with members that previously did not access care
- ☑ Acting as a single point of contact
- ☑ Providing real-time monitoring of barriers and ensuring access to needed services (e.g. transportation)

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PCC Role

The PCC role has had a significant impact on achieving compliance with CMS and DHCS requirements for the HRA, ICP, and ICT processes

This impact applies to all products that have such requirements:

- OneCare
- OneCare Connect
- Medi-Cal SPD

With the addition of the PCC role and other MOC revisions, CalOptima has demonstrated compliance in the following areas:

- Administering the initial HRA within 90 days after enrollment
- Administering a comprehensive annual reassessment within 12 months of the last HRA

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Findings

PCCs directly influenced measure outcomes by supporting the care team to:

- Ensure the development of an ICP for each beneficiary that needs or wants one
- Ensure that the ICP addresses issues identified in the HRA
- Document implementation of the ICP through care management team notes
- Include pertinent specialists required by the beneficiary's health needs on the ICT
- Use professional and credentialed personnel to review the HRA

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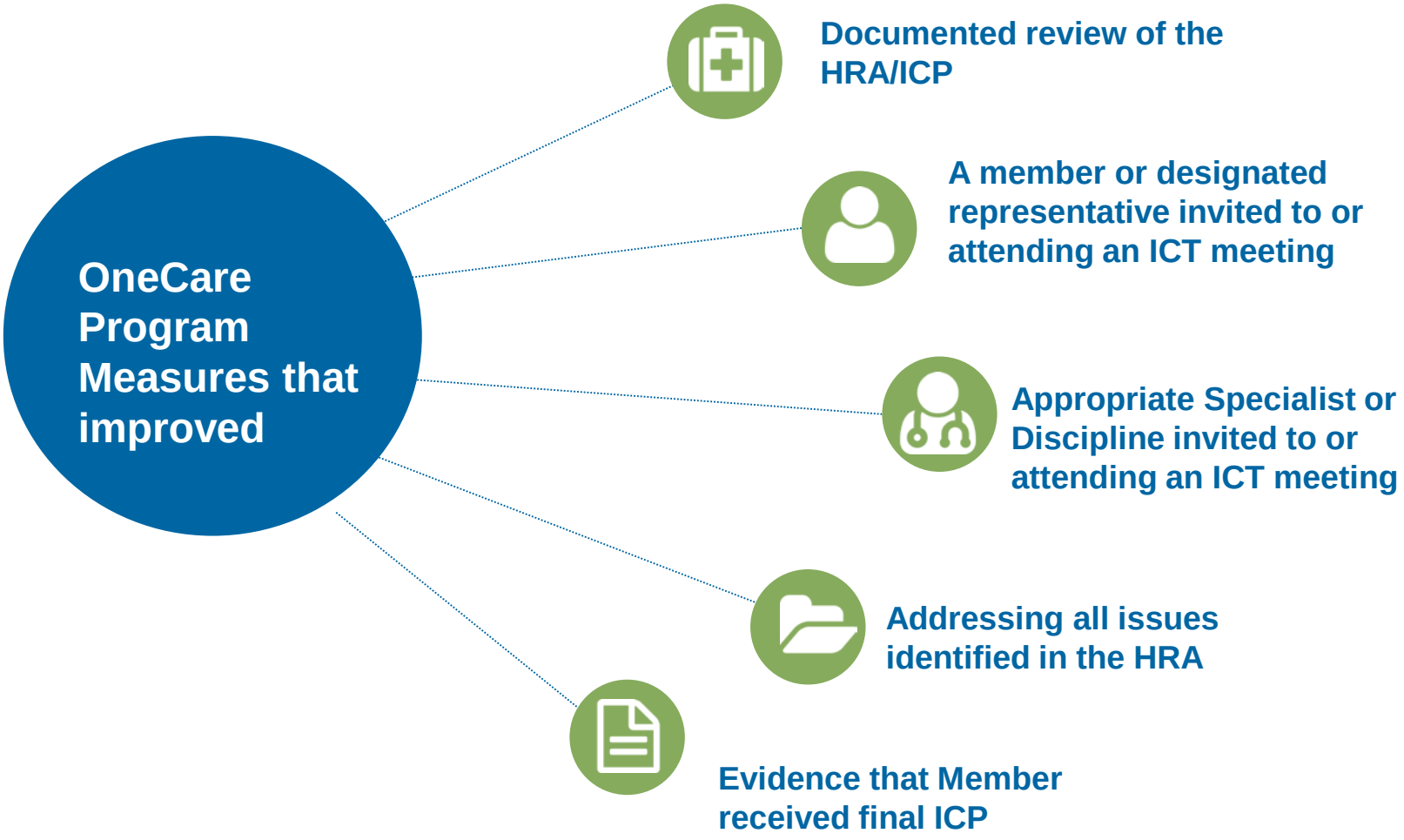
OneCare Model of Care Process



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OneCare Connect Program

For the OneCare Connect program, the following measures improved:

- A member or designated representative invited to or attending an ICT meeting
- PCP invited to or attending an ICT meeting
- Appropriate Specialist or Discipline invited to or attending an ICT meeting
- Addressing all issues identified in the HRA
- A copy of the ICP provided to the member

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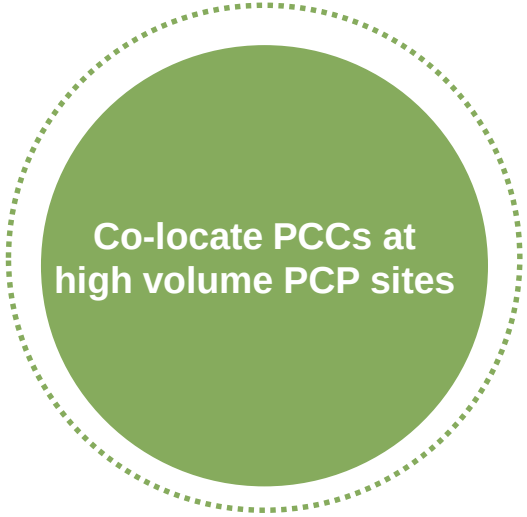
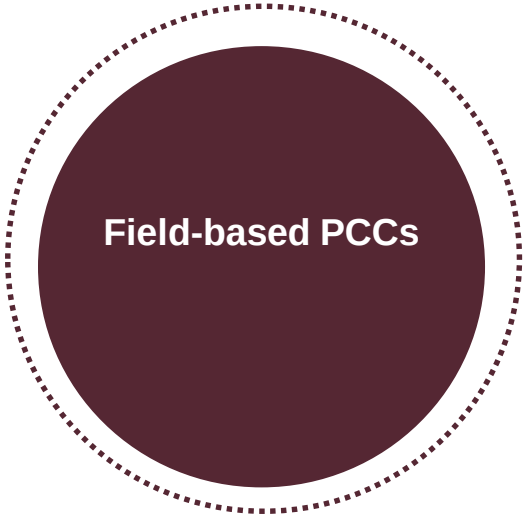
Future Considerations



This would enable the PCC to take a more active role on the care team, initiate the HRA and ICP for new members or members due for a reassessment



Consider placing PCCs at CBOs, ancillary service sites, dialysis centers, etc. that serve a high volume of CalOptima members

PCCs could conduct home visits for high-risk or complex members to follow up on care plan goals, conduct additional assessments, and assist members with transitions of care

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Future considerations (cont'd)

For complex members, non-adherent, or members without caregivers, consider using the PCC to accompany members to physician visits

- PCC can assist the member with communicating with the physician and understanding follow-up orders and care plan updates
- Involve PCCs with transitions of care:
  - PCC can initiate the transition process by visiting patients in the hospital, reviewing the discharge plan, and conducting home visits within 7 and 30 days of discharge
  - Accompany patients to physician follow-up appointments
  - Reinforce red flag symptom identification
  - Ensure medications are filled and understood

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Additional Opportunities

PCCs assist CalOptima with management of behavioral health services in Orange County

- In 2017 CalOptima assumed direct responsibility for behavioral health services
- This is an opportunity to strengthen the integration of physical and behavioral health and the PCC can play a critical role in this process
- Additionally, the PCP satisfaction survey showed relatively low satisfaction with communication regarding mental health services
- PCCs can play an active role in alerting PCPs of their members who are receiving behavioral health services, provide ICP updates, and coordinate care
- Consider placing PCCs at County Mental Health Outpatient clinics

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Member Experience Impact

Members value the quality of communication with their health care providers, want to feel cared for, and desire to be involved with their care

Patient Relationship

The PCC plays an important role by establishing relationships with their assigned members and involving members in their care through implementing the ICP

PCC Skills

The PCC is currently trained on techniques for patient activation and motivational interviewing

Patient Satisfaction

Enhance training to probe for levels of member satisfaction and to set standards for customer service

Opportunity

CalOptima can leverage training used in the Member Services department for PCC training

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Conclusion

Continued refinement of the PCC duties will support ongoing improvement on quality measures important to CalOptima Members, Providers and DHCS

The PCC position has had a significant impact on achieving compliance with CMS and DHCS requirements for the HRA, ICP, and ICT processes

The PCC plays a role in ensuring that the care management program requirements for dual eligible SNP and MMP plans are met

The PCC supports the member as they access care and navigate the health care system based on their needs and required services

For complex and vulnerable patients, a PCC may be particularly important as these members have multiple chronic conditions, require assistance with activities of daily living, may have less social supports, and face barriers based on social determinants of health

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Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

2018 National Committee for Quality Assurance (NCQA) Accreditation Update

- Achieved Commendable Accreditation Status
    - In July 2018, completed tri-annual renewal survey for NCQA Health Plan Accreditation. Received commendable status based on scores from the 2018 renewal survey, 2017 Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). Accreditation scores are based on HEDIS and CAHPS (calculated annually), and accreditation survey (calculated every 3 years).

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HEDIS® 2018 Results

Measurement Year (MY) 2017 Performance

Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Betsy Ha
Executive Director, Quality and Analytics

Kelly Rex-Kimmet
Director, Quality Analytics

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- CalOptima HEDIS 2018 Results
- Member Experience Results
- Next Steps

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Summary Results by Product Line (Compared to CalOptima Goals*)

- Medi-Cal
  - **All DHCS Minimum Performance Levels have been met !!**
  - 56% measures met goal (vs. 44% last year)
  - 76% measures are better than last year (vs. 72% last year)
  - Opportunities for Improvement: Respiratory, Cardiovascular, and Access of Care measures
- OneCare
  - 56% measures met goal (vs. 62% last year)
  - 74% measures are better than last year (vs. 67% last year)
  - Opportunities for Improvement: Diabetes Nephropathy and Breast Cancer Screening
- OneCare Connect
  - 33% measures met goal
  - 74% measures are better than last year
  - Opportunities for Improvement: Diabetes and Behavioral Health measures

*Goals were set to the next higher NCQA percentile based on previous performance. Some goals were “stretch goals”.

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NCQA Percentiles Achievement

LOB	HEDIS	Number of Measures at NCQA National Medicaid/Medicare Percentiles										Total # of measures*	Percent of measures at National 50th percentile or higher
		90th Percentile		75th Percentile		50th Percentile		25th Percentile		<=10th Percentile			
		# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures		
Medi-Cal	2018	13	21%	17	27%	15	24%	9	15%	8	13%	62	73%
	2017	6	10%	12	19%	22	35%	13	21%	9	15%	62	65%
OneCare	2018	1	4%	5	19%	11	41%	5	19%	5	19%	27	63%
	2017	0	0%	5	19%	7	26%	8	30%	7	26%	27	44%
OneCare Connect	2018	2	5%	1	3%	12	31%	16	41%	8	21%	39	38%
	2017	1	3%	1	3%	11	28%	15	38%	11	28%	39	33%

*reported measures in the domains of Effectiveness of Care and Access/Availability of Care only

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HEDIS 2018 Medi-Cal Measures

	2017 Percentile	2018 Percentile
Adult BMI Assessment	75th	**90th**
Weight Assessment and Counseling for Children/Adolescents (BMI)	75th	**90th**
Weight Assessment and Counseling for Children/Adolescents (Nutrition)	90th	90th
Weight Assessment and Counseling for Children/Adolescents (Physical Activity)	90th	90th
Childhood Immunization Status (combo 3)	50th	**90th**
Immunization for Adolescents (HPV)	90th	90th
Immunization for Adolescents (combo 2)	90th	90th
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	75th	**90th**
Comprehensive Diabetes Care - HbA1c Control (<8.0%)	75th	**90th**
Diabetes Monitoring for People with Diabetes and Schizophrenia	50th	**90th**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	90th	90th
Metabolic Monitoring for Children and Adolescents on Antipsychotics	75th	**90th**
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	75th	**90th**

8 measures moved up to 90th percentile

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*Green=higher than last year; Red=lower than last year

HEDIS 2018 Medi-Cal Measures

	2017 Percentile	2018 Percentile
Childhood Immunization Status (comb10)	50th	75th
Immunization for Adolescents (comb1)	50th	75th
Chlamydia Screening in Women	75th	75th
Medication Management for People with Asthma (5-64 yr) - 75%	50th	75th
Controlling High-Blood Pressure	90th	75th
Statin Therapy for Patients with Cardiovascular Disease - Adherence	75th	75th
Comprehensive Diabetes Care (HbA1c Testing)	25th	75th
Comprehensive Diabetes Care (Eye Exam)	75th	75th
Comprehensive Diabetes Care (Medical Attention for Nephropathy)	50th	75th
Comprehensive Diabetes Care (Blood Pressure Controlled <140/90 mm Hg)	75th	75th
Statin Therapy for Patients with Diabetes (therapy)	75th	75th
Statin Therapy for Patients with Diabetes (adherence)	75th	75th
Antidepressant Medications Management (Continuation Phase Treatment)	50th	75th
Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia	25th	75th
Non-Recommended Cervical Cancer Screen in Adolescent Females	50th	75th
Appropriate Treatment for Children with URI	50th	75th
Prenatal and Postpartum Care (Postpartum Care)	50th	75th

10 measures moved up to 75th percentile. 1 measure moved down to 75th percentile.

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*Green=higher than last year; Red=lower than last year

HEDIS 2018 Medi-Cal Measures

	2017 Percentile	2018 Percentile
Lead Screening in Children	50th	50th
Breast Cancer Screening	50th	50th
Cervical Cancer Screening	25th	**50th**
Asthma Medication Ratio (5-64 years)	50th	50th
Statin Therapy for Patients with Cardiovascular Disease (Therapy)	25th	**50th**
DMARD Therapy in Rheumatoid Arthritis	50th	50th
Antidepressant Medications Management (Acute Phase Treatment)	50th	50th
Follow-up Care for Children Prescribed ADHD Medication (Continuation Phase)	25th	**50th**
Annual Monitoring for Patients on Persistent Medications (ACE)	50th	50th
Annual Monitoring for Patients on Persistent Medications (Diuretics)	50th	50th
Annual Monitoring for Patients on Persistent Medications (Total)	50th	50th
Use of Imaging Studies for Low Back Pain	50th	50th
Use of Multiple Concurrent Antipsychotic Medications in Children and Adolescents	25th	**50th**
Prenatal and Postpartum Care (Timeliness of Prenatal Care)	50th	50th
Adolescent Well-Care Visits	50th	50th

4 measures moved up to 50th percentile

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*Green=higher than last year; Red=lower than last year

HEDIS 2018 Medi-Cal Measures

	2017 Percentile	2018 Percentile
Pharmacotherapy management of COPD exacerbations (Corticosteroid)	25th	25th
Pharmacotherapy management of COPD exacerbations (Bronchodilator)	50th	25th
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications	25th	25th
Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	<=10th	**25th**
Adults' Access to Preventive/Ambulatory Health Services (65+)	<=10th	**25th**
Children and Adolescents' Access to Primary Care Practitioners (12-24months)	25th	25th
Children and Adolescents' Access to Primary Care Practitioners (12-24months)	25th	25th
Children and Adolescents' Access to Primary Care Practitioners (7 - 11 years)	25th	25th
Children and Adolescents' Access to Primary Care Practitioners (12 - 19 years)	25th	25th

2 measures moved up to 25th percentile.
1 measure moved down to 25th percentile

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*Green=higher than last year; Red=lower than last year

HEDIS 2018 Medi-Cal Measures

	2017 Percentile	2018 Percentile
Appropriate Testing for Children with Pharyngitis	<=10th	<=10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	<=10th	<=10th
Persistence of Beta Blocker Treatment after a Heart Attack	25th	<=10th
Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase)	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (20-44)	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (45-64)	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (Total)	<=10th	<=10th
Well-Child Visits in the First 15 Months of Life (6+ visits)	<=10th	<=10th

1 measure moved down to <=10th percentile

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*Green=higher than last year; Red=lower than last year

Medi-Cal Measure Results

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Children and Women's Health

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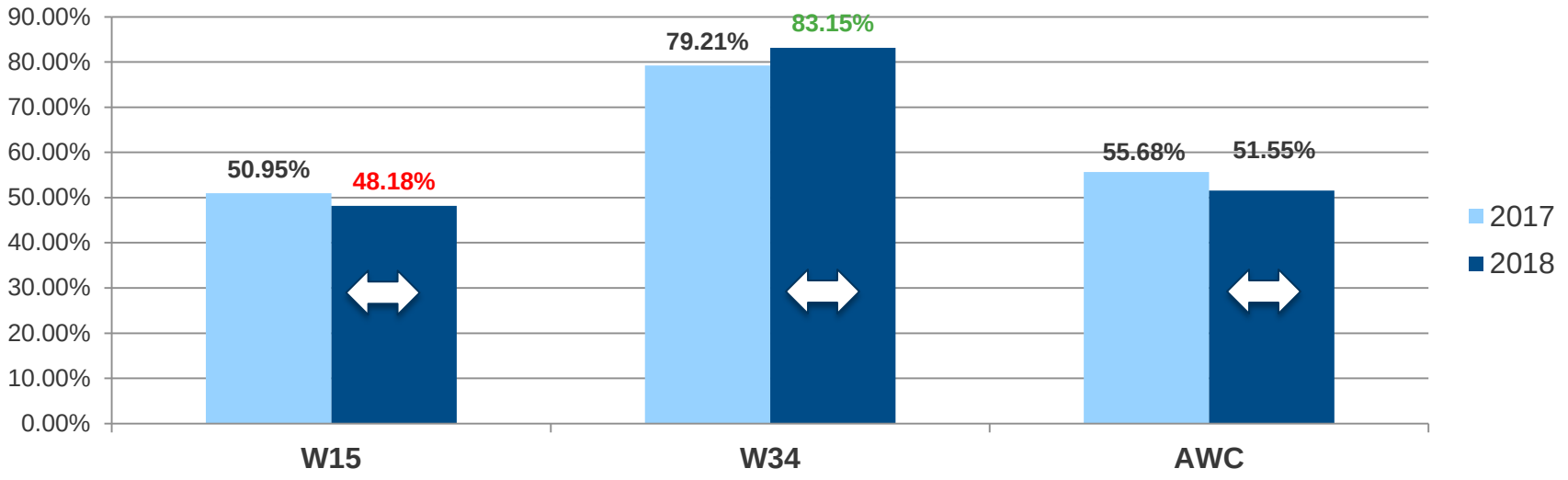
HEDIS 2018 Results: Medi-Cal Well Child Visits



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Goal	Reporting Requirements**
Well-Child Visits in the First 15 Months of Life - Six Well Child Visits (W15)	62.06%	68.66%	72.46%	56.11%	
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	72.45%	78.51%	82.77%	80.64%	MPL, P4V
Adolescent Well-Care Visits (AWC)	50.12%	59.72%	68.06%	55.96%	P4V

*Red = less than 50th percentile, Green= met goal, MPL met

↑ ↓ statistically higher or lower ↔ statistically no difference

**RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

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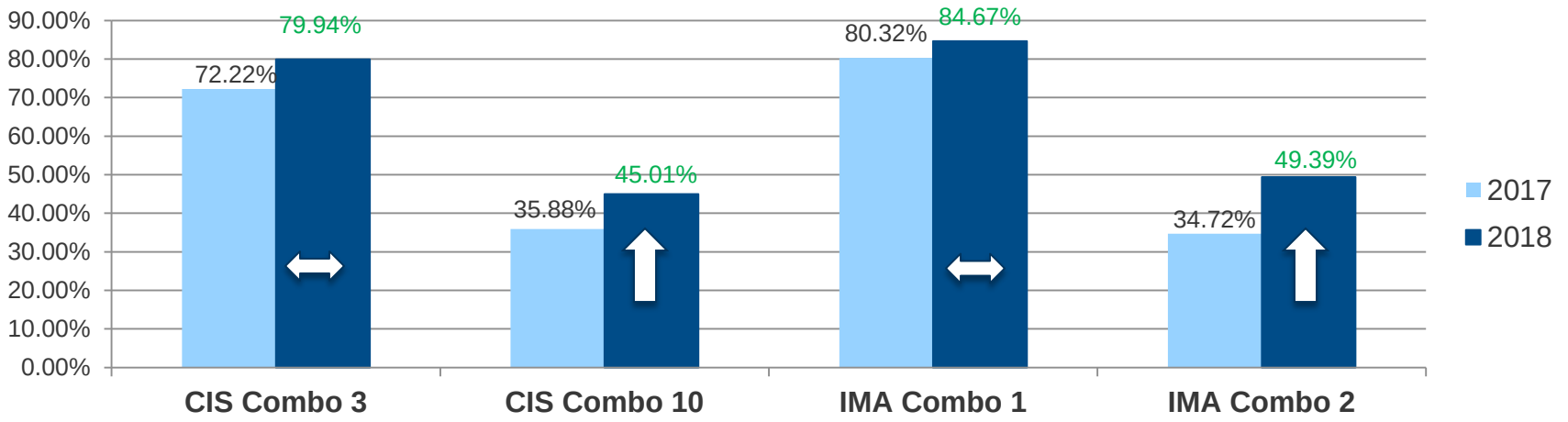
HEDIS 2018 Results: Medi-Cal Immunizations



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Goal	Reporting Requirements**
Childhood Immunization Status (CIS)					
CIS - combo 3	71.58%	75.91%	79.32%	**74.39%**	**MPL**
CIS - combo10 ++	33.09%	39.66%	48.47%	**37.23%**	ACC, P4V, RS
Immunizations for Adolescents (IMA)					
IMA - Combo 1 ++	77.62%	83.89%	86.81%	**81.73%**	ACC, **MPL**
IMA - Combo 2	19.79%	24.62%	30.39%	**30.39%**	RS

***Red = less than 50th percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value**

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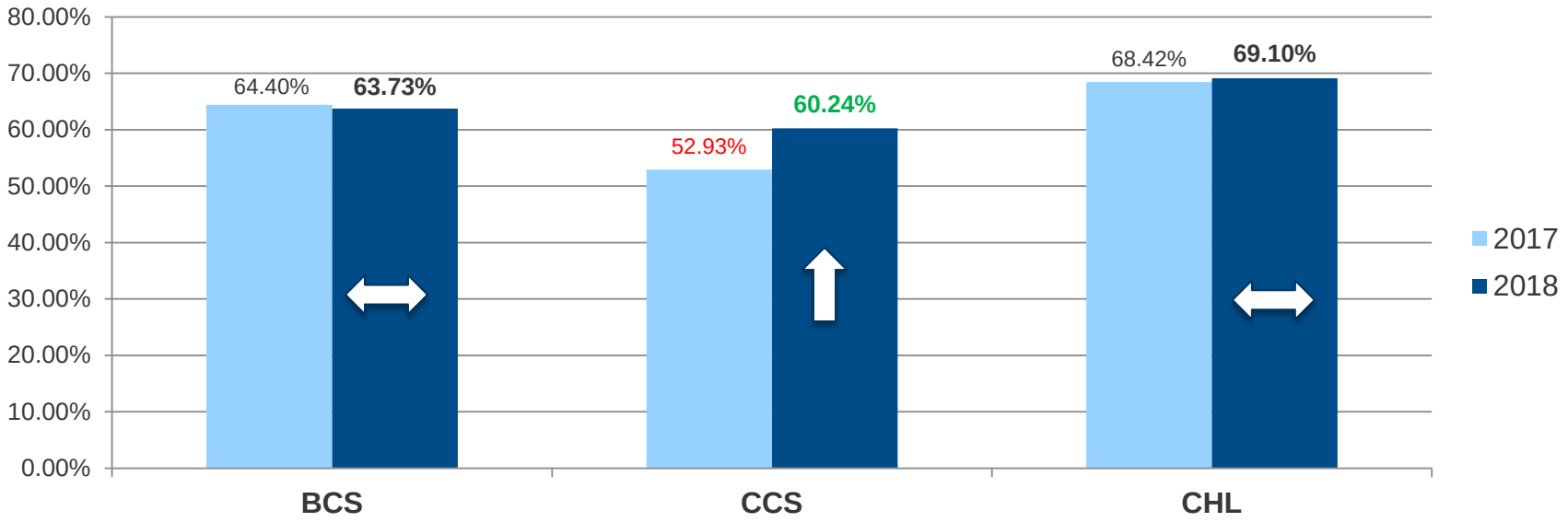
HEDIS 2018 Results: Medi-Cal Women's Health



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Goal	Reporting Requirements*
Breast Cancer Screening (BCS)	58.99%	65.52%	70.29%	65.52%	ACC, P4V, RS
Cervical Cancer Screening (CCS)	58.48%	65.90%	70.80%	58.48%	ACC,MPL, P4V, RS
Chlamydia Screening (CHL)	56.69%	63.73%	71.45%	71.45%	ACC, RS

***Red = less than 50th percentile, Green= met goal, MPL met**

↑ ↓ statistically higher or lower ↔ statistically no difference

****RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value**

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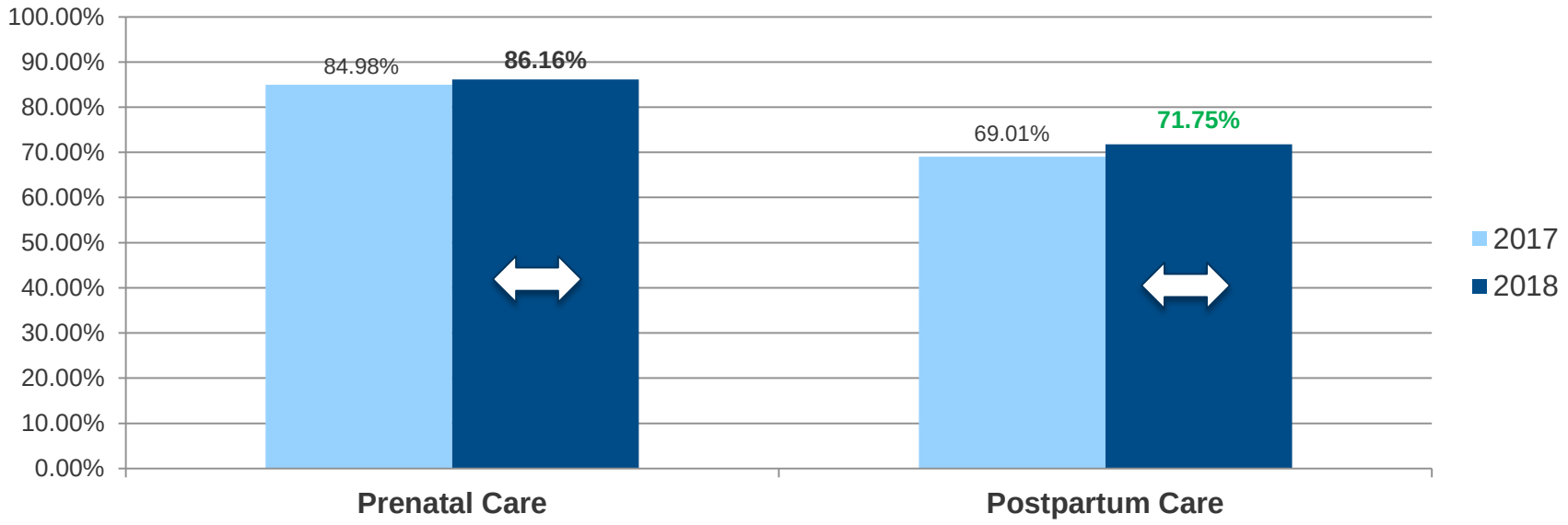
HEDIS 2018 Results: Medi-Cal Prenatal and Postpartum Care



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	83.56%	88.59%	91.67%	86.79%	ACC, MPL, RS
Postpartum Care	64.38%	69.44%	73.67%	69.44%	ACC, MPL, RS

*Red = less than 50th percentile, Green= met goal, MPL met

↑ ↓ statistically higher or lower ↔ statistically no difference

**RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

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Care for Chronic Conditions

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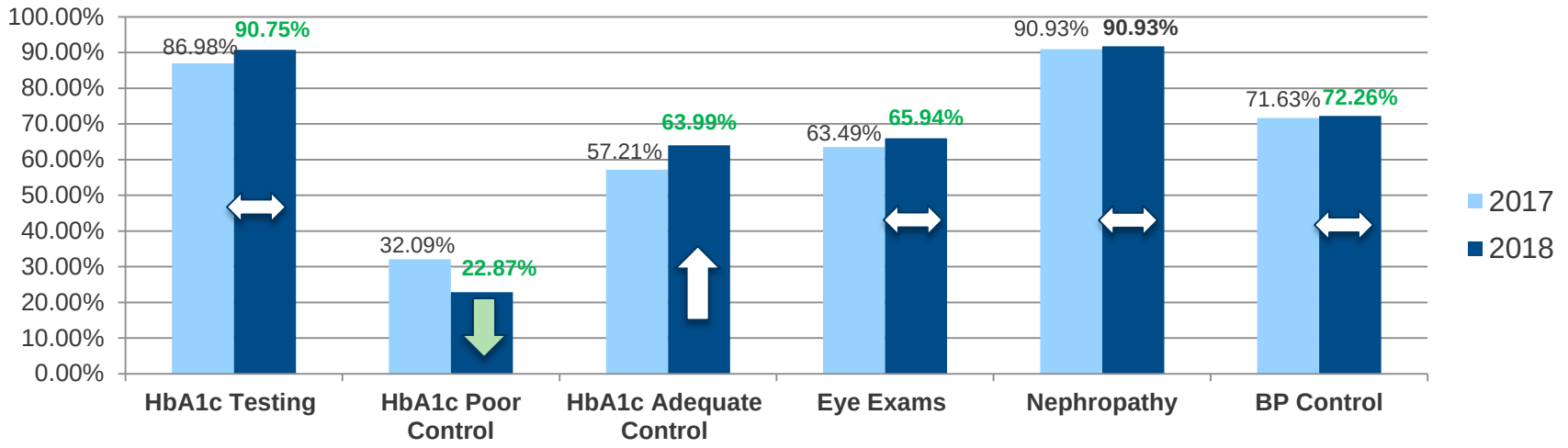
HEDIS 2018 Results: Medi-Cal Comprehensive Diabetes Care



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Goal	Reporting Requirements*
HbA1c Testing	87.10%	90.06%	94.71%	87.10%	ACC, MPL, P4V
HbA1c Poor Control (>9.0%) (Lower is better)	41.12%	35.52%	26.27%	29.07%	ACC, MPL
HbA1c Adequate Control (<8.0%) ++	48.87%	53.65%	63.03%	59.12%	ACC, MPL, RS
Eye Exams	55.11%	63.33%	70.57%	65.83%	ACC, MPL, P4V, RS
Nephropathy Monitoring	90.27%	91.67%	94.81%	91.24%	ACC, MPL, RS
BP Control (<140/90) ++	60.60%	68.57%	79.82%	72.24%	ACC, MPL, RS

***Red = less 50th percentile, Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings**
↑ ↓ statistically higher or lower ↔ statistically no difference
***RS=Health Plan Ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value**

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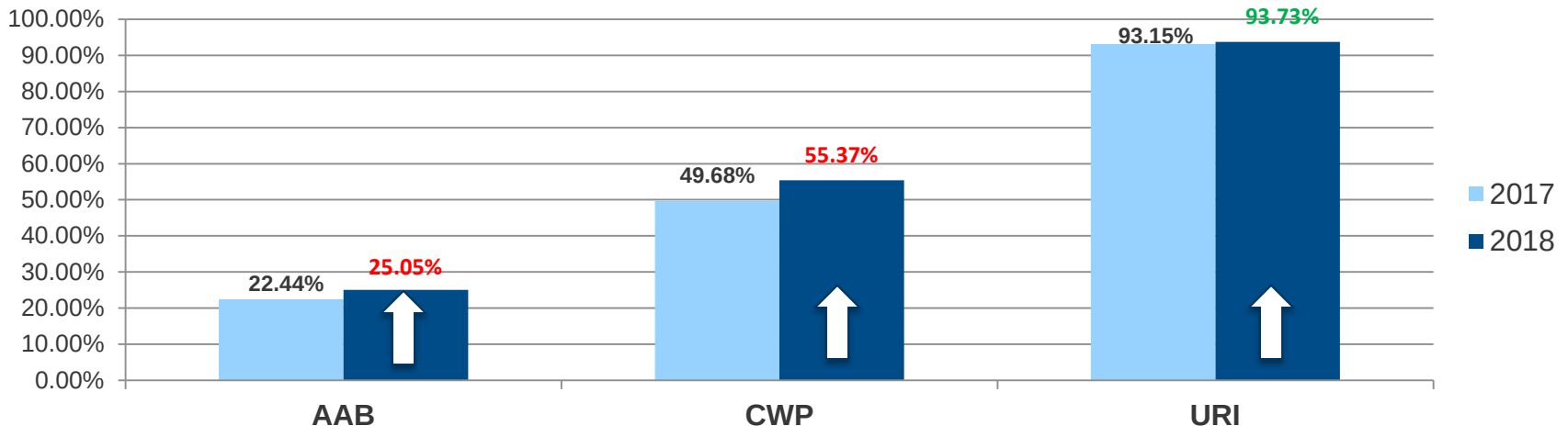
CalOptima A Public Agency Better. Together.

HEDIS 2018 Results: Medi-Cal Respiratory Conditions



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Goal	Reporting Requirements*
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	28.72%	33.74%	39.53%	24.91%	ACC,**MPL**, RS
Appropriate Testing for Children with Pharyngitis (CWP)	75.21%	82.90%	88.00%	67.15%	ACC, P4V, RS
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	89.67%	93.54%	95.98%	93.54%	ACC, P4V, RS

***Red = less than 50th percentile, Green= met goal, MPL met**

↑ ↓ statistically higher or lower ↔ statistically no difference

**RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

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OneCare Results

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HEDIS 2018 OneCare Measures

	2017 Percentile	2018 Percentile
Comprehensive Diabetes Care - HbA1c Control (<8.0%)	50th	**90th**
Care for Older Adults (SNP) - Medication Review	50th	**75th**
Care for Older Adults (SNP) - Pain assessment	75th	75th
Comprehensive Diabetes Care (Blood Pressure Controlled <140/90 mm Hg)	75th	75th
Use of high-risk medications in the elderly (one prescription)	<=10th	**75th**
Adults' Access to Preventive/Ambulatory Health Services (age 20-44)	50th	**75th**
Adult BMI Assessment	25th	**50th**
Care for Older Adults (SNP) - Functional status assessment	25th	**50th**
Controlling High-Blood Pressure	50th	50th
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	25th	**50th**
Comprehensive Diabetes Care (Eye Exam)	75th	50th
Statin Therapy for Patients with Diabetes (Therapy)	<=10th	**50th**
Statin Therapy for Patients with Diabetes (Adherence)	50th	50th
Annual Monitoring for Patients on Persistent Medications (ACE)	25th	**50th**
Adults' Access to Preventive/Ambulatory Health Services (age 45-64)	75th	50th
Adults' Access to Preventive/Ambulatory Health Services (age 65+)	25th	**50th**
Adults' Access to Preventive/Ambulatory Health Services (Total)	50th	50th

1 measure moved up to 90th percentile. 3 measures moved up to 75th percentile. 6 measures moved up to 50th percentile. 2 measures moved down to 50th percentile

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*Green=higher than last year; Red=lower than last year

HEDIS 2018 OneCare Measures

	2017 Percentile	2018 Percentile
Colorectal Cancer Screening	25th	25th
Annual Monitoring for Patients on Persistent Medications (Total)	50th	25th
Medication Reconciliation Post-Discharge	<=10th	25th
Potentially Harmful Drug-Disease Interactions in the Elderly	<=10th	25th
Use of high-risk medications in the elderly (two or more prescriptions)	<=10th	25th
Breast Cancer Screening	25th	<=10th
Comprehensive Diabetes Care (HbA1c Testing)	25th	<=10th
Comprehensive Diabetes Care (Medical Attention for Nephropathy)	<=10th	<=10th
Annual Monitoring for Patients on Persistent Medications (Diuretics)	75th	<=10th
Non-Recommended PSA-Based Screening in Older Men	<=10th	<=10th

3 measures moved up to 25th percentile
1 measure moved down to 25th percentile
3 measures moved down to <=10th percentile

*Green=higher than last year; Red=lower than last year

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OneCare Connect Results

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HEDIS 2018 OneCare Connect Measures

	2017 Percentile	2018 Percentile
Use of high-risk medications in the elderly (one prescription)	50th	**90th**
Use of high-risk medications in the elderly (two prescriptions)	50th	**90th**
Adult BMI Assessment	25th	**75th**
Care for Older Adults (Medication Review)	25th	**50th**
Care for Older Adults (Pain assessment)	50th	50th
Pharmacotherapy management of COPD exacerbations (Corticosteroid)	25th	**50th**
Pharmacotherapy management of COPD exacerbations (Bronchodilator)	50th	50th
Controlling High-Blood Pressure	50th	50th
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	25th	**50th**
Comprehensive Diabetes Care - HbA1c Control (<8.0%)	25th	**50th**
Comprehensive Diabetes Care (Eye Exam)	50th	50th
Comprehensive Diabetes Care (Blood Pressure Controlled <140/90 mm Hg)	50th	50th
Statin Therapy for Patients with Diabetes (Therapy)	50th	50th
Medication Reconciliation Post-Discharge	25th	**50th**
Potentially Harmful Drug-Disease Interactions in the Elderly	25th	**50th**

2 measures moved up to 90th percentile. 1 measure moved up to 75th percentile. 6 measures moved up to 50th percentile.

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*Green=higher than last year; Red=lower than last year

HEDIS 2018 OneCare Connect Measures

	2017 Percentile	2018 Percentile
Breast Cancer Screening	25th	25th
Colorectal Cancer Screening	25th	25th
Care for Older Adults (Functional status assessment)	25th	25th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	50th	25th
Persistence of Beta Blocker Treatment after a Heart Attack	90th	25th
Statin Therapy for Patients with Cardiovascular Disease – Therapy	<=10th	25th
Statin Therapy for Patients with Cardiovascular Disease – Adherence	<=10th	25th
Comprehensive Diabetes Care (Medical Attention for Nephropathy)	25th	25th
Statin Therapy for Patients with Diabetes – Adherence	25th	25th
Osteoporosis Management in Women Who Had a Fracture	50th	25th
Follow-up After Hospitalization for Mental Illness (30-day)	50th	25th
Follow-up After Hospitalization for Mental Illness (7-day)	75th	25th
Annual Monitoring for Patients on Persistent Medications (ACE)	<=10th	25th
Annual Monitoring for Patients on Persistent Medications (Diuretics)	25th	25th
Annual Monitoring for Patients on Persistent Medications (Total)	25th	25th
Non-Recommended PSA-Based Screening in Older Men	25th	25th

3 measures moved up to 25th percentile. 5 measures moved down to 25th percentile.

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*Green=higher than last year; Red=lower than last year

HEDIS 2018 OneCare Connect Measures

	2017 Percentile	2018 Percentile
Comprehensive Diabetes Care (HbA1c Testing)	<=10th	<=10th
DMARD Therapy in Rheumatoid Arthritis	<=10th	<=10th
Antidepressant Medications Management (Acute Phase Treatment)	<=10th	<=10th
Antidepressant Medications Management (Continuation Phase Treatment)	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (age 20-44)	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (age 45-64)	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (age 65+)	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (Total)	<=10th	<=10th

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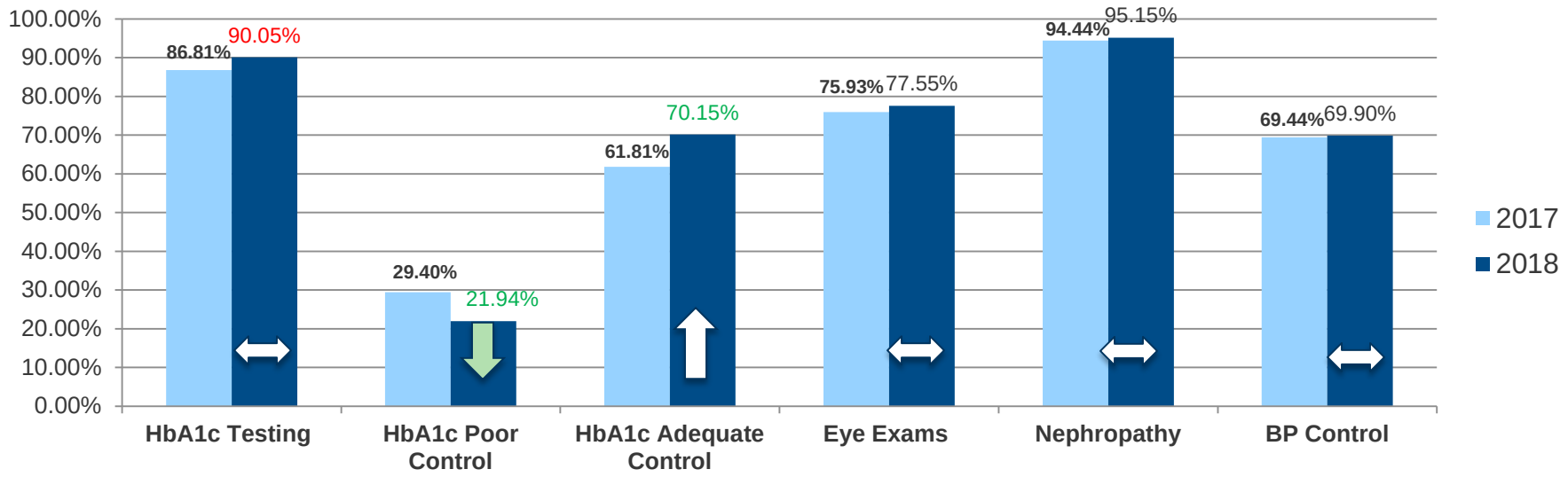
*Green=higher than last year; Red=lower than last year

HEDIS 2018 Results: OneCare Connect Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 50th percentile	4-Star/ 75th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements*
Comprehensive Diabetes Care (CDC)					
1. HbA1c Testing	93.82%	95.62%	97.08%	91.73%	CMS
2. HbA1c Poor Control (>9.0%) **	36%	27%	20%	27%	Star
3. HbA1c Adequate Control (<8.0%)	64.72%	72.45%	76.05%	64.72%	CMS
4. Eye Exams	59%	72%	81%	81%	Star
5. Nephropathy Monitoring	94%	96%	98%	96%	Star
6. BP Control (<140/90)	65.82%	73.72%	80.12%	70.83%	CMS

*Red = less than 3-Star or 50th percentile, Green= met goal **Star cut points are previous year (from 2018 Technical Notes, 2019 cut points are not available ↑↓ statistically higher or lower ↔ statistically no difference **Triple weighted for STARS

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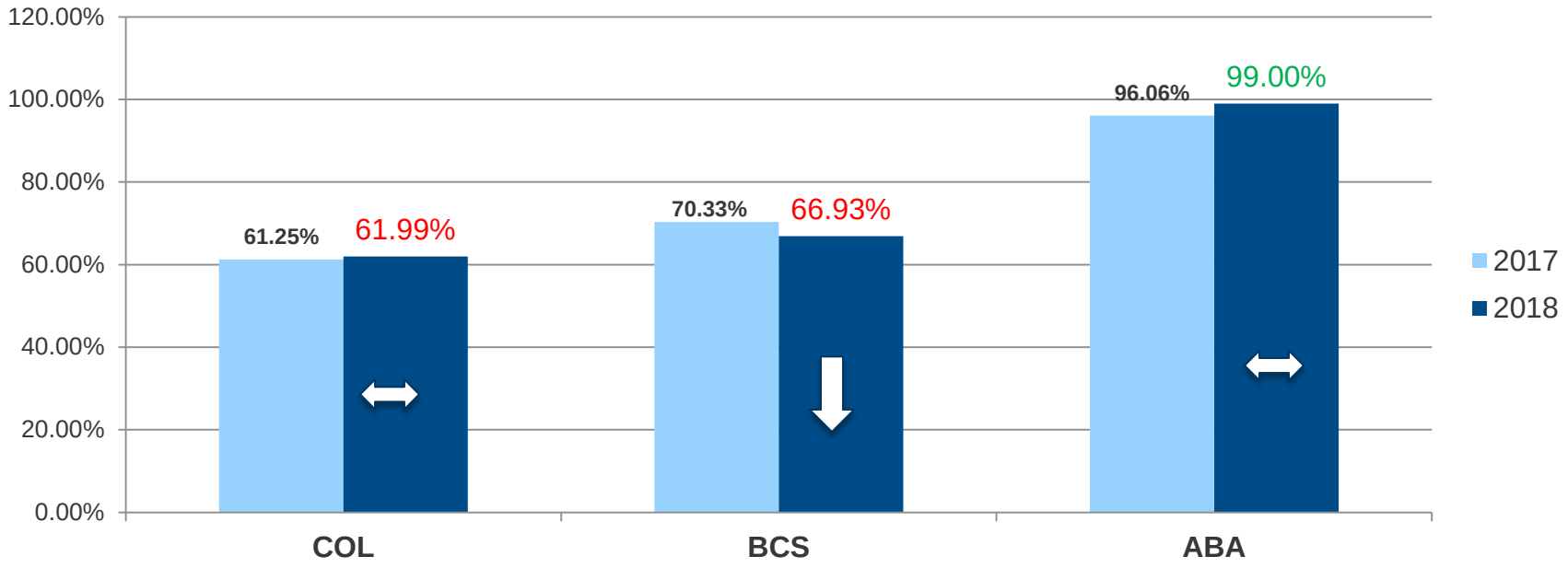
HEDIS 2018 Results: OneCare Connect Prevention and Screening



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Colorectal Cancer Screening (COL)	63%	72%	80%	63%	Star
Breast Cancer Screening (BCS)	70%	78%	84%	78%	Star
Adult BMI Assessment (ABA)	81%	94%	98%	98%	Star

*Red = less than 3-Star or 50th percentile, Green= met goal **Star cut points are previous year (from 2018 Technical Notes, 2019 cut points are not available ↑↓ statistically higher or lower ↔ statistically no difference

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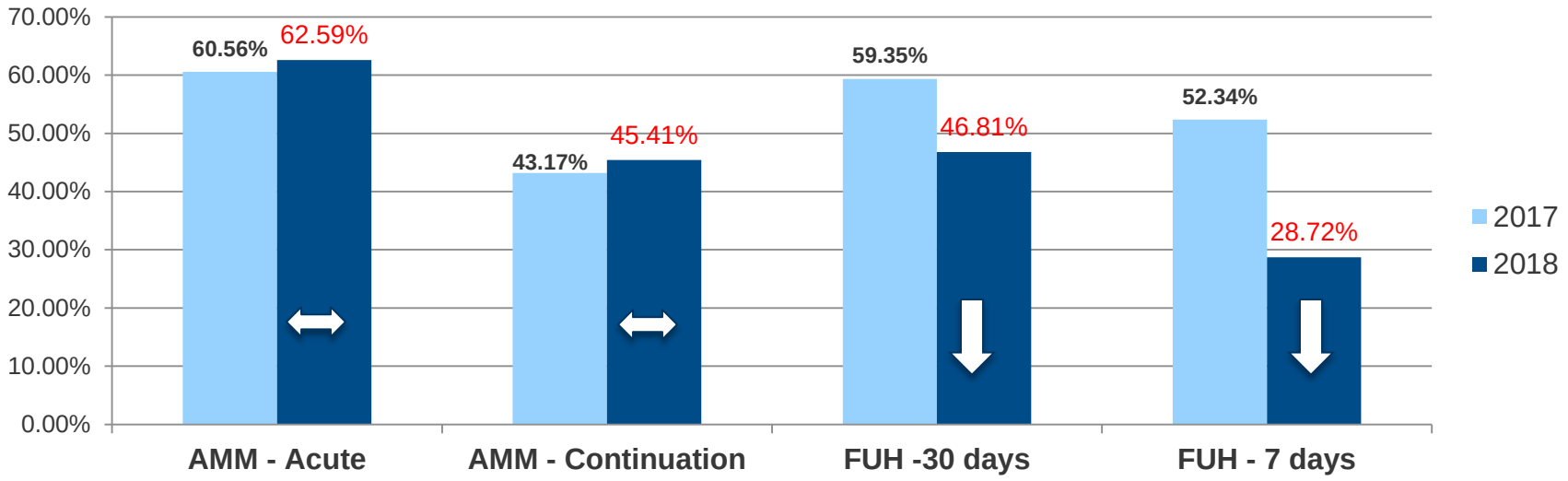
HEDIS 2018 Results: OneCare Connect Behavioral Health



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	69.11%	75.00%	79.61%	63.45%	CMS
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	53.90%	59.80%	66.71%	47.09%	CMS
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	52.40%	65.49%	78.79%	60.89%	**CMS, Withhold**
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++	31.21%	46.38%	60.51%	56%	**CMS, Withhold**

***Red =less than 3-Star or 50th percentile, Green= met goal ++ Quality Withhold measure**
↑ ↓ statistically higher or lower ↔ statistically no difference

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CalOptima A Public Agency Better. Together.

Medi-Cal Member Experience (CAHPS)

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Member Experience Surveys

- Medi-Cal Adult and Child surveys are conducted at plan level
  - Sample size for Adult survey is 1,350 and the response rate was 24%
  - Sample size for Child survey is 1,650 and the response rate was 28%
- Medi-Cal Adult and Child survey at the Health Network level are also conducted
  - Total Adult survey sample size for all Health Networks is 17,183 and the overall response rate is 30%
  - Total Child survey sample size for all Health Networks is 15,397 and the overall response rate is 37%
- Medicare CAHPS surveys conducted for OneCare at plan level and OneCare Connect at both plan level and health network level
  - Results for OC/OCC Member Experience Surveys are not yet available

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Medi-Cal Adult Survey Results

- Results are consistent with last year (below the 25th percentile)
- Pain points which keep us low scoring:
  - Member Experience Benchmarks have risen across the nation (bar continues to be raised)
  - "Rating of Health Plan" is double weighted; our score is at less than 25th percentile
  - Coordination of Care is statistically significantly lower than last year
  - Getting Needed Care, Getting Care Quickly, Rating of Specialist all stay below the 25th percentile
  - There were three (3) health networks with many areas statistically below the CalOptima average

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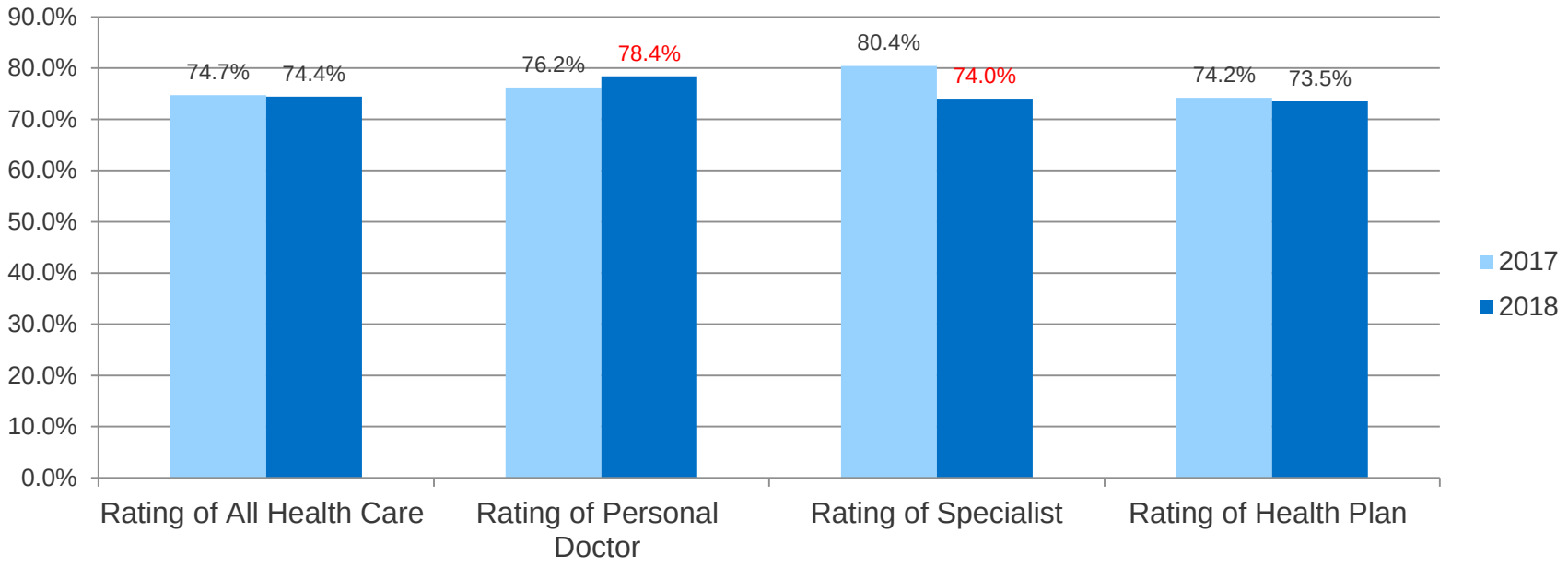
Medi-Cal CAHPS Adult Member Survey Results



NCQA QC 2017 National Medicaid Percentiles	25th Percentile	50th Percentile	75th Percentile	90th Percentile	P4V
Rating of All Health Care	71.7	74.5	77.2	79.4	No
Rating of Personal Doctor	79.3	81.6	83.7	85.5	Yes
Rating of Specialist	79.5	81.9	84.1	86.1	No
Rating of Health Plan*	72.9	76.4	79.5	81.4	No

Red = less than 25th percentile, *double weighted

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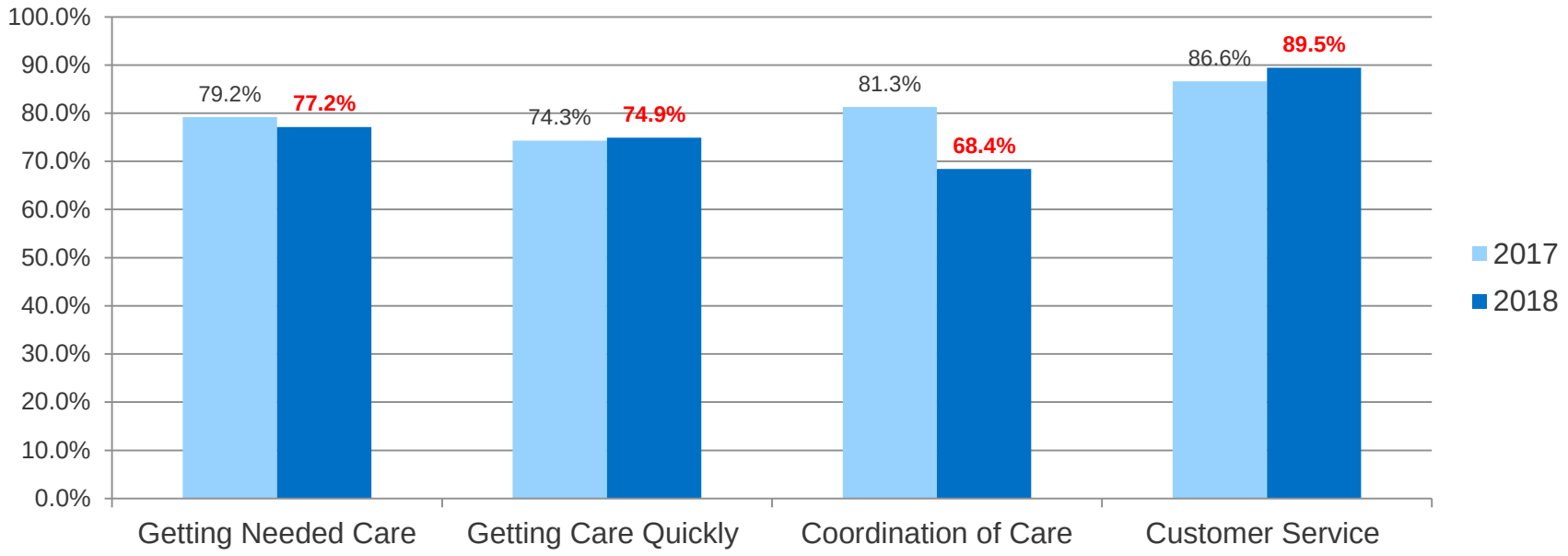
Medi-Cal CAHPS Adult Member Survey Results



NCQA Quality Compass 2017 National Medicaid Percentiles	25th Percentile	50th Percentile	75th Percentile	90th Percentile	P4V
Getting Needed Care	79.7	82.7	84.7	86.6	Yes
Getting Care Quickly	79.6	82.2	84.5	86.6	Yes
Coordination of Care	80.8	83.8	86.0	88.5	No
Customer Service	86.6	88.4	90.1	91.2	No

Red = less than 25th percentile

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Medi-Cal Child Survey Results

- Results improved from the previous year
  - “Rating of Health Plan” is statistically significantly higher than the previous year
- Pain points which keep us low scoring:
  - Rating of Specialist is lower than the previous year
  - Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service continue to be areas of focus
  - There were two (2) health networks with many areas statistically below the CalOptima average

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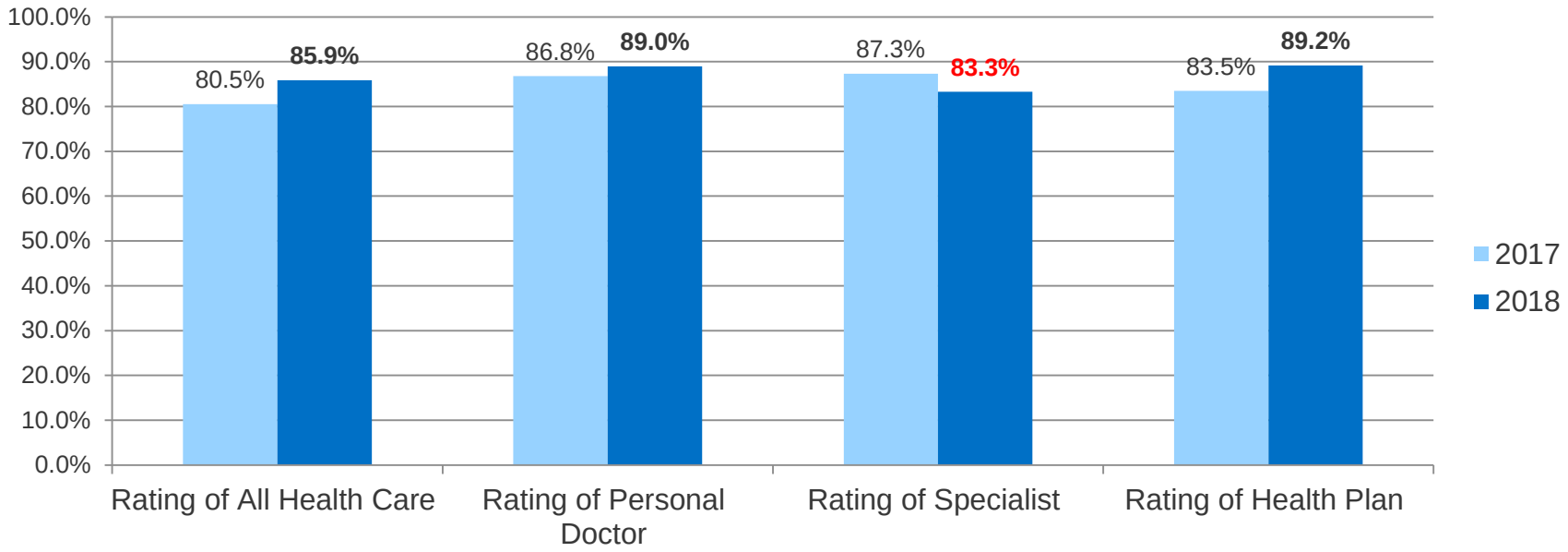
Medi-Cal CAHPS Child Member Survey Results

(Parents Satisfaction with Their Child's Care)



NCQA Quality Compass 2017 National Medicaid Percentiles	25th Percentile	50th Percentile	75th Percentile	90th Percentile	P4V
Rating of All Health Care	85.1	87.1	88.7	90.1	No
Rating of Personal Doctor	87.9	89.5	90.7	91.9	Yes
Rating of Specialist	84.9	87.2	89.7	91.4	No
Rating of Health Plan*	83.8	86.0	88.9	90.3	No

Red = less than 25th percentile, *double weighted

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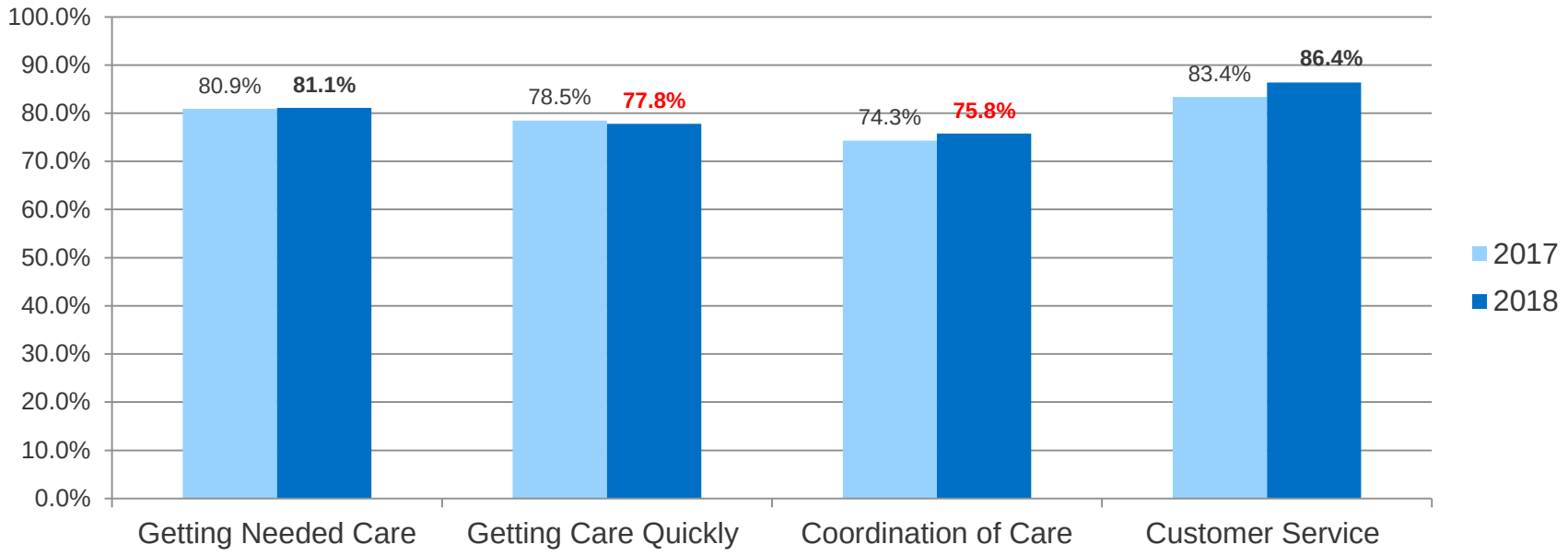
Medi-Cal CAHPS Child Member Survey Results

(Parents Satisfaction with Their Child's Care)



NCQA Quality Compass 2017 National Medicaid Percentiles	25th Percentile	50th Percentile	75th Percentile	90th Percentile	P4V
Getting Needed Care	80.8	85.1	88.7	90.6	Yes
Getting Care Quickly	86.1	89.5	92.1	93.7	Yes
Coordination of Care	80.2	83.2	85.8	88.3	No
Customer Service	86.4	88.1	89.7	91.2	No

Red = less than 25th percentile,

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Next Steps

- Implement strategies on low performing areas
  - Priority areas will include low areas of performance and areas related to strategic initiatives (DHCS MPL, NCQA Accreditation, NCQA Health Plan Ratings, Medicare Star Rating)
  - Member Experience Initiatives (provider coaching)
- Present results to stakeholder groups and committees
- Await NCQA Health Plan Rating
- Calculate P4V scores and payments
- Begin preparations for HEDIS 2019!

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Member Experience Initiatives Update

Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Betsy Ha
Executive Director, Quality and Analytics

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You may recall..

- An enterprise-wide Member Experience Subcommittee was formed to improve member experience at various settings and ensure members have access to quality health care.
- Senior leadership executive sponsors from operations, medical affairs and provider network participate in this subcommittee.
- Strategy: Identify focus areas and implement initiatives to improve member experience.

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How Do We Identify Member Pain Points?

- Member Experience Surveys
  - Performance at the plan, health network and physician level
- Timely access survey
- Monitor and review member complaints/Potential Quality Indicators (PQIs)
- Member needs assessment

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Areas of Focus

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Getting Needed Care and Getting Care Quickly

Strategy

- Member and provider education on access to care

Activities

- Member and provider communications on CalOptima access standards
- Articles in member communications about how to better access care
  - Articles about how to get care
  - Tips on “Preparing for Your Office Visit”
  - Articles about how to obtain referrals and authorizations

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Getting Needed Care and Getting Care Quickly (cont.)

Strategy

- Partner with health networks to increase access for members

Activities

- Specific member experience and access performance shared with health networks (e.g. CAHPS, timely access)
- Corrective action plans issued to health networks if timely access standards are not met
- Pilot provider incentive for extended office hours
- CalOptima Days: Collaborate with health networks and participating provider offices to host a day dedicated for preventive health screenings

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How Well Doctors Communicate and Customer Service

Strategy

Educate providers on strategies and techniques to improve member experience (Provider Coaching Pilot)

Activities

- Improving customer service through trainings and workshops for:
  - Physicians (1), managers and supervisors (1) and staff who provide customer service to CalOptima members (3)
  - Scheduled for October and November
- Physician-Patient Communication Online CME (12 month access)

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How Well Doctors Communicate and Customer Service (cont.)

Activities (cont.)

- Physician Shadow Coaching Sessions
  - Voluntary program offered to 25 physicians
  - Full-day observation in the office and exam room with patient consent
  - Participating physician receives a written report with recommendations along with an action plan specific to the provider's performance goals
  - Two-week and three-month follow up
  - Physician outreach in progress: Four physicians completed coaching; six physicians agreed to participate and finalizing coaching date
  - Health networks are notified of their providers who participate

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Rating of Health Plan

Strategy

- Enhance coordination and redesign of member materials

Activities

- Update the Medi-Cal New Member Packet (e.g. member ID cards, health network selection form, health network descriptions pack) for member ease of use
- Refresh the covers to member materials (e.g. member handbook, provider directory, annual notice)
- Streamline member communication

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Rating of Health Plan (cont.)

Strategy

- Expand methods for members to access services

Activities

- Member Portal
  - Members can access their personal health information when needed (24 hours a day) via personal electronic devices
  - Members can register for an account and complete self-service requests
  - June 2018: soft launch (internal use only)
  - Member release: Beginning of 2019
- Community grants (Intergovernmental Transfer Program)

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Next Steps

- Continue with the planned interventions
- Evaluate effectiveness of interventions
- Implement strategies on low performing areas
  - Priority areas will include:
    - Care Coordination
    - Referrals and Authorizations
- Continued collaboration with health network and providers to improve member experience

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Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Whole-Child Model Update

Whole-Child Model Clinical Advisory Committee

In addition to the Whole-Child Model (WCM) Family Advisory Committee, the WCM Clinical Advisory Committee (CAC) is formed pursuant to All Plan Letter 18-011 to ensure clinical and behavior health services for children with California Children's Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with County CCS, WCM Family Advisory Committee, and Health Network CCS Providers.

The WCM-CAC reports to the CalOptima Quality Improvement Committee (QIC). On August 14, 2018, the QIC approved the WCM-CAC Charter. CalOptima is in the process of accepting recommendations to fill the designated committee seats with CCS Paneled physicians to include representation in the following:

- Neonatology
- Neurology
- Endocrinology
- Orthopedics
- Hematology/Oncology
- CCS Paneled primary care pediatrician
- Whole Child Model Health Network Medical Director

The first WCM-CAC will be held in September 2018.

Whole-Child Model Claims Payment Process

CalOptima and its health networks issue authorizations based on member, provider, and service code levels. Claims payments, when applicable, are based on the details in the authorization. Whereas, the CCS program issues Service Authorization Requests (SARs) based on member and diagnosis/conditions. Multiple claims potentially involving multiple providers and multiple services/visits can be paid based on a single SAR. While CalOptima plans to proactively outreach to members and providers to obtain detailed information to issue new authorizations as a part of the WCM transition, some claims for CCS services may be submitted without a CalOptima or health network authorization.

In order to promote a smooth transition to WCM and ensure continued access to services for members, CalOptima staff recommends implementing a transition period that permits claim payments in certain situations when there is no CalOptima or health network authorization. The recommendation is that for dates of service from January 1, 2019 through June 30, 2019, CalOptima and the health networks

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pay for CCS services provided by contracted or non-contracted providers, for eligible children who were enrolled in CCS program prior to January 1, 2019, as long as there is an active CCS SAR and other claim payment requirements are met. All inpatient services are excluded from this proposed exception, and depending on member's eligibility, will require a CalOptima or a health network authorization.

This recommendation will be presented for consideration to the CalOptima Board of Directors' Finance and Audit Committee on September 18, 2018, and then for consideration at the CalOptima Board of Directors Meeting on October 4, 2018.

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Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

The Bright Steps Perinatal Support Program
Executive Summary

CalOptima is responsible for the provision of the Bright Steps Perinatal Support Program to all eligible members except those members enrolled in the Kaiser Foundation Health Plan.

Contracted Providers

- CalOptima contracts with certified Comprehensive Perinatal Services Program (CPSP) Providers to deliver evidenced-based prenatal and postpartum care to members.
- Certified Providers are required to have current Medi-Cal enrollment with the California Department of Health Care Services, be CalOptima credentialed, and be recognized by Orange County Health Care Agency.
- Certified Providers shall provide the opportunity for members to have enhanced support services, including: health education, psychosocial, and nutrition assessments each trimester, in accordance with The American College of Obstetricians and Gynecologists (ACOG) and CPSP protocols.
- Contracted Providers shall not provide enhanced support services to members already receiving these services from another contracted Provider. Comprehensive care shall exclusively be provided to a member by one contracted Provider during any given time period.

Program Components:

- Implement a comprehensive risk assessment tool for pregnant members that is comparable to ACOG and CPSP services. Individualized care plans must be developed to include nutrition, psychosocial, and health education interventions when indicated by identified risk factors.
- Provide member with referrals to: 1) The Women, Infant, and Children (WIC) Program; 2) DHCS approved genetic diagnostic center for screening services: 3) Dental services, if necessary, and; 4) Other services, as needed.
- Provide identified high-risk members with referrals to appropriate specialists, in a reasonable timeframe.
- Provide members support by: 1) Promoting breastfeeding to members; 2) Evaluating members for domestic abuse, and reporting suspected or observed abuse; and 3) Discussing member concerns regarding prenatal care, services, or any information provided by the OB/GYN.
- Outreach and marketing to CalOptima members and physicians through various avenues (existing member mailings, newsletters, CalOptima website/Member Portal, etc.)
- Postpartum reminders and incentives for visits to be completed between 21 and 56 days.

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Program Goals:

- Comprehensive support for CalOptima pregnant members.
- Early identification, assessment, and intervention of CalOptima pregnant members.
- Improved coordination between CalOptima, Bright Steps contracted Providers, OB/GYNs, and health network case management staff.
- Recognition in the community.
- Improved outcomes for mothers and babies.
- Improve member satisfaction.

Program Performance Measures:

- HEDIS rates – Prenatal and Postpartum Care (PPC) Measure
- NICU days
- Birth weights
- Preterm births <37 weeks
- Program satisfaction

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Bright Steps Perinatal Support Program

Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Pshyra Jones
Director of Health Education & Disease Management

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Introduction to Bright Steps Program

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Why do we need a perinatal support program?

- CalOptima has contractual requirements to provide members with access to a comprehensive perinatal support program
- Improve our member experience
- Improve clinical outcomes for mothers and babies
- Improve our HEDIS performance
- Prevent unplanned inpatient admissions
- Prevent pre-term delivery and low birth weight

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Bright Steps Program Components

- Initial assessment, trimester reassessments, postpartum assessment, interventions and follow-up services in:
  - Obstetrics
  - Nutrition
  - Health Education
  - Psychosocial Services
- Comprehensive care exclusively provided by one contracted Provider during any given time
- Coordination with CPSP provider, OB/GYNs, complex case management and community resources

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Bright Steps Program Components, cont.

- Referrals to Women, Infant, and Children (WIC), genetic screening, dental care, and other services as needed
- Postpartum reminders and incentives for visits within 21-56 days
- Outreach and program marketing strategy to increase identification and member engagement

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Program Goals

- Improve early identification of CalOptima pregnant members
- Improve coordination between CalOptima, Bright Steps contracted Providers, OB/GYNs, and health network case management staff
- Improve quality outcomes for mothers and babies
- Improve member experience
- Recognition in the community

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Program Performance Measures

- HEDIS rates – Prenatal and Postpartum Care (PPC) Measure
- NICU days
- Birth weights
- Preterm births <37 weeks
- Program satisfaction

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Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Depression Screening Initiative Update

On December 1, 2016, CalOptima Board of Directors approved a $1 million physician incentive program funded by Intergovernmental Transfer (IGT) 1 to increase the rate of depression screenings conducted during annual wellness visits for members ages 12 to 18.

On February 20, 2018, the Quality Assurance Committee (QAC) recommended that the Board of Directors ratify a $20 increase per depression screening for all screens completed by physicians for eligible members retroactively to May 1, 2017 and authorize incentive payments of $50 per depression screening for members prospectively through May 2019, or until available funding has been exhausted, whichever comes first. The Committee also asked staff to continue to monitor the volume of screenings and provide an update to the QAC in Q3 2018.

The Board of Directors approved the recommendation on March 1, 2018.

Activities completed since the February 2018 QAC meeting include:

- 4,259 members (through June 30, 2018) have received depression screenings.
- CalOptima has conducted in-person visits to provider offices to support office staff and provide guidance on billing procedures.
- CalOptima has also created a quick reference billing guide for office staff, which led to a decrease in the number of claim denials.
- CalOptima has developed a provider survey form that will be used to measure the effectiveness and success of the program.

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Medi-Cal

CalOptima

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Health Homes Program (HHP)

Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Emily Fonda, M.D., M.M.M., C.H.C.Q.M.
Medical Director for Care Management, LTSS and Senior Programs

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HHP Background: Authorization

- Federal: Authorized under Section 2703 of the Affordable Care Act (ACA)
  - State option to implement
  - 90 percent funding for eight quarters and 50 percent thereafter
  - Must be available to dual eligible
- State: California's AB 361 (2013) authorizes HHP participation
  - Implementation permitted if no General Funds used
  - Requires Department of Health Care Services (DHCS) evaluation within two years of state's initial implementation
- CalOptima scheduled to Go-Live:
  - July 1, 2019: Members with chronic conditions
  - January 1, 2020: Members with Serious Mental Illnesses or Serious Emotional Disturbance (SMI)

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DHCS HHP California Model

Department of Health Care Services

Lead Entities

Qualifying Medi-Cal managed care plans (MCP)
Orange County: CalOptima

Community-Based Care Management Entities (CB-CMEs)

Sample organizations include Primary Care Providers, Federally Qualified Health Centers, physician groups, hospitals, and behavioral health entities or MCP

Community and Social Support Services

Sample organizations include supportive housing providers, food banks, employment assistance and social services

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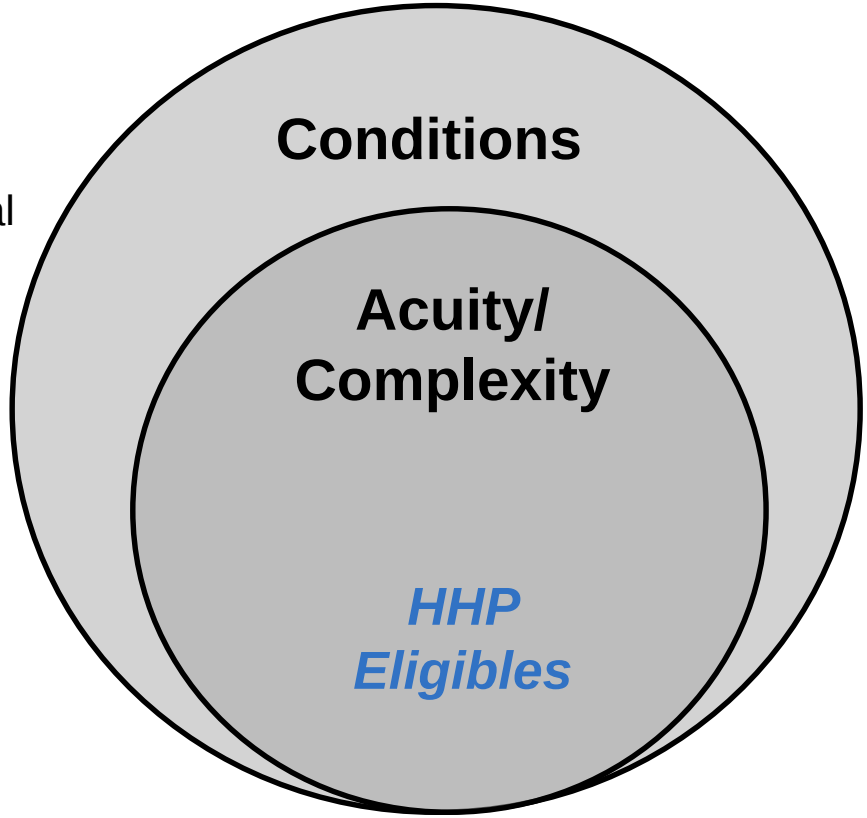
DHCS HHP Member Eligibility

- Medi-Cal members eligible for HHP

1. Conditions/combination of conditions specified by DHCS
   - Chronic physical conditions, including substance use disorder or
   - Serious mental illness/Serious emotional disorder

2. Acuity/complexity (**one** of the below):
   - Three specified conditions
   - One inpatient stay
   - Three Emergency Department (ED) visits in a year
   - Chronic homelessness



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HHP Member Exclusions

- Residing in nursing facility (NF)
- Enrolled in hospice
- Participating in other programs (member must choose as they cannot participate in both)
  - Most county-operated Targeted Case Management (TCM), not Mental Health TCM
  - 1915(c) Waiver programs including HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), and Pediatric Palliative Care (PPC)
  - PACE
  - Cal MediConnect

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Demographics

Languages	Gender
English — 72% Spanish — 21% Vietnamese — 5%	Female — 55% Male — 45%

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Health Network Distribution Based on DHCS Data

Active Outreach		DHCS Assumed Opt-In Rate	CalOptima Assumed Opt-In Rate		
Health Network	**Count**	**Targeted 25%**	**20%**	**15%**	**10%**
Monarch	4,774	1,194	955	716	477
CCN	4,761	1,190	952	714	476
CHOC	3,937	984	787	591	394
Arta	3,050	763	610	458	305
Kaiser	2,096	524	419	314	210
AltaMed	2,048	512	410	307	205
Prospect	1,580	395	316	237	158
Family Choice	1,420	355	284	213	142
Talbert	1,225	306	245	184	123
Noble	1,148	287	230	172	115
United	950	238	190	143	95
AMVI	538	135	108	81	54
HPN Regal	236	59	47	35	24
OC Advantage	44	11	9	7	4
Totals	**27,807**	**6,952**	**5,561**	**4,171**	**2,781**

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HHP Service Requirements

Enhanced Core Service Categories	New Services
• Provide comprehensive care management • Conduct health assessments and develop action plans • Provide comprehensive transitional care • Offer care coordination and health promotion • Offer individual and family support • Make referrals to community and social support services	• Follow up on referrals to ensure services are offered and accessed • Accompany highest risk participants to critical appointments (risk tier criterion determined by MCP) • Assist homeless members with housing navigation • Manage transitions from non-hospital or nursing facility settings, such as jail and residential treatment programs • Assess family/caregiver support • Develop trauma informed care standards

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HHP CB-CME Staffing

- Clinical Consultant
- HHP Director
- Dedicated Care Coordinator
  - 60:1 member to Care Coordination ratio expected after two years
- Housing Navigator for members experiencing homelessness
- Community Health Worker recommended but not required

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Community Services Analysis

- External consultant conducted survey of Orange County community-based organizations (CBOs) providing HHP-like services
  - Surveys conducted September–November 2017

- Results
  - 48 of 72 CBOs responded to survey
    - 14 were Federally Qualified Health Center (FQHC)/Clinics and substantially completed the survey
  - Six community-based organizations with a total 27 sites providing most or all HHP-like services
    - Covering all cities with high-density of potential HHP members projected
    - Four identified as FQHCs or medical clinics

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Approach

- CalOptima acts as CB-CME for all Health Networks (HN) and CalOptima Direct/CalOptima Community Network (COD/CCN) members
  - Exception: Health networks may elect to provide CB-CME services for their assigned members
  - If health network does not elect to provide CB-CME services, then members participating in HHP will need to move to CCN or electing HN
  - CalOptima to “buy” select “new” services that may be leveraged by health networks, e.g., housing related services and accompaniment

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Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Quality Improvement Committee (QIC) Quarter 2 Update

QIC Meeting Dates: June 18, 2018

- Summary

  - The following departments report to the QIC quarterly through various subcommittees:
    - Case Management and Complex Case Management
    - Behavioral Health Integration (BHI)
    - Customer Service
    - Grievance & Appeals (GARS)
    - Health Education & Disease Management (HE & DM)
    - Long-Term Services and Supports (LTSS)
    - Program of All-Inclusive Care for the Elderly (PACE)
    - Pharmacy
    - Utilization Management (UM)
    - Clinical Operations Population Health (COPHS)/Medical Affairs
    - Credentialing Peer Review Committee (CPRC)
    - Access and Availability
  - Accepted minutes from the following subcommittees:
    - Utilization Management Committee: March 22, 2018
    - Behavioral Health Integration QI Committee: February 06, 2018
    - Long-Term Services and Supports: March 19, 2018
    - Grievance & Appeals Committee: November 30, 2017, March 15, 2018
    - Clinical Operations Population Health: May 02, 2018
    - Member Experience: March 20, 2018, April 17, 2018, May 1, 2018, May 15, 2018, May 29, 2018
    - PACE Quality Improvement Committee: March 13, 2018

- Q2 Subcommittee Highlights

  - Behavioral Health Integration Quality Improvement Committee (BHIQIC)
    - Access & Coordination of Care LTC/SNF survey results were presented. Intervention identified providers may need a refresher on how to bill for services and how to request services. CalOptima to engage facilities with the assistance from LTC department and will educate providers on billing process for consults.

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- Inter-disciplinary Care Team (ICT) participation results were shared, and challenges were discussed, although participation rates have improved. Need to identify treating BH providers. Will share County's opinion on Treatment, Payment, Operation HIPAA exception with Full Service Partnerships (FSPs) to increase participation of ICTs.
- BH HEDIS measures (Follow-up after Hospitalization – FUH) goals not met. Working with Magellan to receive detailed level report. The challenge with this measure is because it is conducted post discharge. Will investigate and follow-up with committee on suggestions. Other HEDIS measures, Attention Deficit Disorder (ADD) Initiation and Continuation goals were met at 50th Percentile. ADD Workgroup discussion on choice of alternative intervention to letters and additional funding opportunities.
- Depression screening accomplishments in Q4 were shared. Will present first year analysis at Q2 BHQIC.

- Utilization Management Committee (UMC)
  - 2017 UM Program Evaluation and Workplan was approved with operational metrics:
    - Timeliness of authorization decision overall >98%
    - Appropriate decision making between 72-100%
    - Annual Inter-Rater Reliability assessments average score 90%
    - Use of lay-language 74-100% with high variability among health networks
    - Utilization performance goals PTMPY for bed days, all lines of business were met
    - ED Utilization is higher than anticipated
    - Retail pharmacy costs PMPM for all LOB was below goal
    - LTSS utilization was flat
  - Implementation of Mega Reg components for 2017 were completed
  - Annual review and approval of UM criteria
  - Addition of new benefits with guidelines under development including NMT, transgender services and behavioral health treatment
- Long Term Services and Supports Quality Improvement Subcommittee (LTSS-QISC)
  - Presented Q4 results for the four programs (LTC, CBAS, MSSP and IHSS), as presented in the 2017 Q4 QI Workplan.
  - LTSS Admission and Readmissions work group are in partnership with CBAS facilities. The workgroup meets quarterly and is focusing on participation with the highest utilization. LTC admission workgroup is meeting to explore strategies and best practices to decrease LTC admissions in facilities.
  - Presented an update on the Treatment in Place CMS project.
- Grievance and Appeal Resolution (GARS) Subcommittee
  - Presented Q1 Grievance and Appeal reports (see GARS Member Trend Report)
    - Medi-Cal appeals remain steady comparing Q4 2017 to Q1 2018
    - Medi-Cal grievances increased by 29% form Q4 to Q1
      - Process implemented to improve categorization of grievances which increase grievance volume
      - Areas of Access, Authorization Process and Delay in Service continue to remain high
    - Medi-Cal Provider appeals have decreased slightly from Q4 to Q1

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- OneCare Connect Appeals decreased by 42% from Q4 to Q1
- OneCare Connect Grievances increased by 25% from Q4 to Q1
- OneCare Connect Provider Appeals filed decreased by 45%
- OneCare Appeals, Grievances and Provider Appeals continue to be low

- Credentialing Peer Review Committee (CPRC)
  - Approved CPRC charter and re-signed confidentiality, conflict of interest and non-discriminatory forms
  - Approved GG.1602 Non-Physician Medical Practitioner Policy
  - Significant increase in volume of re-credentialing files due to transition of BH network as of 1/1/2018
  - Developing process for screening provider types not able to enroll in Medi-Cal i.e. Applied Behavioral Analyst (ABA) provider types
  - Working with Network Management on the implement of new DHCS APL 17-019
- Member Experience Subcommittee (MEMX)
  - Customer Service Results average speed of answer goal of answering the phone in less than 30 seconds was not met in Q1. Working on training staff to increase efficiency and reduce handling time of each call. Actively recruiting to fill open positions. All other customer services goals were met.
  - Access and Availability subcommittee presented 2017 Timely Access Survey Results. Areas not met were:
    - Urgent and non-urgent specialty visits (including psychiatrists)
    - Triage and Screening
    - Returning Urgent Messages
    - Emergency Messaging
  - Provider Coaching initiative to increase member satisfaction moving forward. Finalized the provider outreach list and provider materials. Outreach to providers began the first week of June. Contract vendors are scheduling coaching visits with providers who agree to participate.
- Clinical Operations Population Health Subcommittee (COPHS)
  - 2018 Case Management Program was approved. Initiatives for Case Management on target, measuring: Health Risk Assessments (HRA) collected and completed, Pilot members with high ER utilization, Member Experience with Case Management, and Model of Care activities
  - 2018 Health Management Program was approved
  - Annual adoption of Clinical Practice Guidelines was approved
  - Intense collaboration with CCS County has begun in preparation for the Whole Child Model (WCM) implementation on January 1, 2019
- PACE QIC
  - Presented Q1 Quality Performance Improvement Update (QAPI)
  - Membership increased from June 2017 to June 2018. Membership is expected to grow with PACE expanding its service area to all Orange County effective 7/1/2018.
  - Physician Order for Life Sustaining Treatment (POLST) utilization has reached 100% in Q4 2017 and Q1 2018.
  - Medication Reconciliation Post-Discharge met goal and exceeded 2017 HEDIS 90th percentile

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        - PACE will continue with their plan to implement inpatient avoidance strategies, enhance complex care coordination, increase community-based PACE PCP's and expand alternative care settings (ACS).
    - Quality Analytics Update
        - In the home stretch for HEDIS 2018. HEDIS audit data collection processes and rate production successfully completed. No administrative measures at risk as not reportable
        - Medi-Cal Preliminary HEDIS results
            - All DHCS measures with Minimum Performance Levels (MPL) met
            - Accreditation Measures with noted improvements include Adult BMI, Cervical Cancer Screening, Childhood Immunization Combo 10, CDC HbA1c
        - OneCare CMS Star Level
            - All Star measures are at or higher than last year
            - Colorectal Cancer Screening reached 3-Star
            - Diabetes blood sugar control reached 5-Star
            - New star measure Medication Reconciliation Post-Discharge reached 3-Star

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Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Quality Improvement 1st Quarter 2018 Workplan Dashboard

1st Quarter 2018 Workplan Dashboard

- Work Plan Structure
  - Program Oversight
  - Quality of Clinical Care – Updates from
    - Case Management
    - Behavioral Health
    - LTSS
    - HE/DM
    - Pharmacy
  - Quality Analytics – QIPs/PIPs
  - Quality of Clinical Care - HEDIS Measures
  - Quality of Service
    - Member Experience (CAHPS, Customer Service, GARS)
    - Network Adequacy
  - Safety of Clinical Care
    - Pharmacy
    - Quality Improvement (FSR, Facility Monitoring)
  - Compliance – Reported to AOC
    - Delegation Oversight of HN (UM, CR, Claims)
    - Delegation Oversight of HN (CCM)
- Changes/Updates to QI Workplan
  - LTSS Measures
    - Retire 4 measures (lines 36-39)
    - Add 10 additional measures (lines 40-49)
    - Removed 2 duplicative measures from QI related to CBAS/SNF Satisfaction (lines 50 and 51)
  - CM Measures
    - Corrected # of days (lines 20 and 22)
  - Pharmacy Measures
    - Added OC/OCC to Goals (lines 79 and 80)
    - Added new measure for Pharmacy (line 96)
  - QIP/PIP
    - Added new OneCare PIP focused on Chronic Conditions (line 89)
- 84% On Track (Green), 16% Areas of Concern (Yellow), 0% At Risk (Red)

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- Areas of Concern (Yellow)
  - Quality of Clinical Care
    - Case Management – reported below target for HRA collection and review of HRA assessments for OC Initial HRA, however exceeded goal for OC Annual. Did not meet the goal for OCC Annual HRA.
    - QIP/PIP for OCC/OC projects are in process
  - Quality of Clinical Care – HEDIS
    - AMM (Anti-depressant Medication Management) Measure at Risk for MC
    - COA (Care of Older Adults) OC/OCC Rates slightly lower compared to same time period for last year
  - Safety of Clinical Care
    - Full Scope FSR completion was greater than 36 months in Q1 due to resource and staffing issues
    - PQI processing TAT of cases is greater than 90 days due to high volume of cases that were processed from Q4. Seeing improvement as # of referrals to QI decreased significantly
  - Quality of Service
    - Waiting on 2018 CAHPS scores, will report at next QIC
    - Customer Service Q1 Abandonment Rate target met, however Average Speed of Answer (ASA) target not met due higher call volume, increase in average handle of each call, and inadequate staffing resources
  - Network Adequacy functions related to:
    - Initial and Recredentialing TAT processing times short of goal
    - Appointment timely access scores for in 2017 not met, 2018 not available yet
  - Compliance
    - Delegation Oversight of HN - Several HN did not meet goal for UM. A&O to issue Corrective Action Plans and continue to monitor performance improvement.

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#	Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
1	QIC	Program Oversight	Quality Improvement	Esther Okajima/Kelly Rex-Kimmet	2018 QI Annual Oversight of Program and Work Plan	Approve QI Program and Workplan for 2018	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Descritpion-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018	None	3/1/2018	
2	QIC	Program Oversight	Quality Improvement	Esther Okajima/Kelly Rex-Kimmet	2017 QI Program Evaluation	Evaluate QI Program for 2017	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018	None	3/1/2018	
3	QIC	Program Oversight	Utlization Management	Tracy Hitzeman	2018 UM Program and UM Workplan	Approve UM Program and Workplan for 2018	UM Program and UM Work Plan will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018-(UM Pogram Only)	Work Plan will go in 2Q to QIC	3/1/2018	
4	QIC	Program Oversight	Utlization Management	Tracy Hitzeman	2017 UM Program Evaluation	Evaluate UM Program for 2017	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation	Approved at UMC 3/22/2018; QIC 4/10/2018; QAC 5/16/18 Will go to BOD 6/7/2018	Evaluation will go in 2Q to QIC	6/7/2018	
5	QIC	Program Oversight	Case Management	Sloane Petrillo	2018 Case Management Program	Approve CM Program for 2018	CM Program will be adopted on an annual basis; Delegation oversight reported by DOC	Annual Adoption	CM Program on target to present at QIC.	CM Program will go in 2Q to QIC	5/8/2018	
6	QIC	Program Oversight	HE & DM	Pshyra Jones	2018 Health Management Program	Approve HM program for 2018	HM Program will be adopted on an annual basis	Annual Adoption	Approved at QIC 2/13/2018	None	2/13/2018	
7	QIC	Program Oversight	Quality Improvement	Esther Okajima	Credentialing Peer Review Committee Oversight	Peer Review of Provider Network	Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC ; Delegation oversight reported by A&O quarterly to CPRC.	Quarterly Adoption of Report	CPRC 4Q was presented to QIC on 2/13/2018	Continue to monitor provider network and review findings at CPRC.	5/8/2018	
8	QIC	Program Oversight	Behavioral Health	Donald Sharps MD	BHQIC Oversight	Internal and External oversight of BHI Activities	BHQI meets quarterly to monitor and identify improvement areas of member and provider services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.	Quarterly Adoption of Report	Q1 - BHI continues to monitor delegated functions; meets regularly with delegate; requests for training of delegate when delegate is not meeting requirements BHQIC 4Q was presented to QIC on 2/13/2018.	Continue to monitor and offer solutions/ suggest improvements when needed. BHQI is schedule to report again in 4/10/2018	4/10/2018	
9	QIC	Program Oversight	Utlization Management	Sharon Fetterman	UMC Oversight	Internal and External oversight of UM Activities	UMC meets quarterly; it monitored medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results	Quarterly Adoption of Report	UMC 4Q was presented to QIC 1/23/18. With the exception of IRR restults, which will be presented in 2Q.	1Q will be presented to QIC along with IRR Assessment results	4/10/2018	
10	QIC	Program Oversight	Quality Analytics	Kelly Rex-Kimmet	Member Experience SubCommittee Oversight	Oversight of Member Experience activities to improve member experience	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	MEMX reported to QIC on 3/13/2018 their 4Q Updates	Presenting Q1 data to QIC on 6/12/18	Q2	
11	QIC	Program Oversight	LTSS	Steven Chang	LTSS QISC Oversight	LTSS QI Oversight	The LTSS Quality Improvement Sub Committee meets on a quarterly basis and addresses key components of regulatory, safety, quality and clinical initiatives.	Quarterly Adoption of Report	LTSS 3Q was presented to QIC 1/23/18.	4Q will be presented to QIC on 4/10/2018	Q2	
12	QIC	Program Oversight	Medical Affairs	Tracy Hitzeman/ Kelly Rex-Kimmet	Clinical Operations/Population Health Oversight	Clinical Operations Oversight	This COPHS monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care.	Quarterly Adoption of Report	COPHS 4Q was presented to QIC on 02/13/18.	Continue to monitor	Q2	
13	QIC	Program Oversight	GARS	Ana Aranda	GARS Committee	GARS Committee Oversight	The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Quarterly Adoption of Report	Reviewed Q1 data at GARS Committee on 5/31/18. Addressed outstanding action items with attendees.	Presenting Q1 data to QIC on 6/12/18	Q2, 2018	

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#	Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
14	QIC	Program Oversight	PACE	Dr. Miles Masatsugu	PACE QIC	PACE QIC Oversight	The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC	Quarterly Adoption of Report	Element 4 Pneumococal Immunization at 90%, Element 5 Infection Conttrol Respiratory and Skin/Soft Tissue rates below national benchmarks, Element 6 POLST Completion 100%, Element 7 Medication Review 100%, Element 8 Functional Status Assessment Completion 100%, Element 9 Pain Screening 100%, Element 10 Diabetic Eye Exams 88%, Element 11 Diabetes BP Control 100%, Element 12 Nephropathy Monitoring 93%, Element 16 Medication Reconcilliation Post-Discharge 100%, Element 17 Specialty Appointment Rate 88%, Element 18 Hospital Bed Days 2958 BD/K/Y, Element 19 ER Visits 820 Visiits/K/Y, Element 20 30-Day All-Cause Readmissions 12%, Element 22 Disenrollments in the 1st 90 days continues to fall, Element 24 Transportation > 1 hr ride violations 0, and Element 25 Transportation On-Time Performance 93.3%.	Identify high utilizers and begin complex care coordination. RN Case Manager and Pharmacist positions to be opened on July 1st, 2018. Implement revised PACE PCP Incentive Program once it is authorized by the Board of Directors. Audit remediation in the upcoming quarter which will focus on service delivery requests and IDT assessments.	Q3 2018	
15	QIC	Program Oversight	Quality & Analytics	Esther Okajima	Quality Program Oversight - NCQA	Maintain "Commendable" NCQA accreditation rating	Monitor specific HEDIS measures listed below. Conduct NCQA Renewal Survey submission May 2018	Maintain Commendable Status. Accreditation evaluated every three years. HEDIS measures scored annually.	2018 Renewal submission in process. In the final stages with a target submission date of May 22, 2018. On-Site Audit prep in process with a scheduled on-site date of July 9-10.	Continue preparations to load documents into the IRT, and ready to submit by May 22.	Aug-18	
16	QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet/ Esther Okajima	Quality Program Oversight - Health Plan Rating	Maintain or exceed NCQA 4.0 health plan rating	Monitor specific HEDIS measures listed below and Maintain Commendable Status.	Achieve 4.0 Health Plan Rating - Annual Assessment	Will submit NCQA renewal survey on May 22nd. HEDIS and CAHPS will be submitted in June.	Awaiting NCQA accreditation results which will be reported in August of 2018. Health Plan Ratings will be report in September 2018.	Q3	
17	QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet/ Tracy Hitzeman	Quality Program Oversight - Quality Withold	Earn Quality Withhold Dollars back for OneCare Connect in OCC QW program.	Quarterly monitoring and reporting to OCC Steering Committee and QIC	Annual Assessment	Board of directors approved OCC Quality Withhold distribution strategy for remaining four years of OCC Quality Withhold program. (2016-2019 MY) Earn back for MY 2016 is 50%. (down from 75% in prior year 2015) . Earn back for MY 2017 is projected to be 50%. MY2018 measure results are being monitored.	Distribute 2016 earnings following DHCS confirmation of dollars earned for 2016 performance. Await DHCS confirmation of percentage of measures passed for MY2017 performance.	Q2	
18	QIC	Program Oversight	Quality Analytics	Kelly Rex-Kimmet/ Sandeep Mital	Pay for Value	• Implement and monitor health network performance on P4V measures during the year; • Calculate and distribute the P4V incentive payments to participating health networks for MY 2017; and • Calculate and distribute the P4V incentive payments to participating providers in CCN for MY 2017	• Generate and share Prospective Rate reports monthly for all health networks on their performance on adult and child clinical measures • Complete review of 2017 measures at the end of the year • Hold provider education with Provider relations team to educate CCN providers and provider relations team on the new CCN P4V program. • Implement CCN P4V Prospective Rate reporting	National and State benchmarks	•Prospective Rate reports for all health networks on their performance on adult and child clinical measures is being generated and shared with health networks on a monthly basis. •Prospective Rate reports for select community clinics in the CalOptima Community Network (CCN) on their performance on adult and child clinical measures is being generated and shared with clinics on a monthly basis. •Provider education for CCN providers to increase their awareness and understanding of the CCN P4V program has been planned for May 2018 with the Provider Relations team.	•Calculate and distribute the P4V incentive payments to participating health networks for MY 2017; and •Calculate and distribute the P4V incentive payments to participating providers in CCN for MY 2017	Dec-18	
19	QIC	Program Oversight	Medical Affairs	Tracy Hitzeman	MOC Dashboard 2016-2019	Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter, 2017 ; Re-evaluate measurements through data analysis	Define analytics and resources to support the Model of Care for OC/OCC & SPD members; Implement activities to meet or exceed measures	Meet or exceed defined MOC Metrics	MOC metrics are being updated to meet the prefromance reporting measures outlined in the QIPE_PPME Technical Specifications, The QI Workplan include activities for OC/OCC and will be monitored below. For OCC activities include OCCHRA collection and completion, OCC ICP Completion, OCC DIscussion of care goals, OCC PDSA. For OC activities include CCIP, QIP and HRA initial and annual.	See next steps captured in QI Workplan below	Q2	
20	COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Review of Health Risk Assessments for OCC New Beneficiary's	OCC- Health Risk Assessment Outreach for members in the OneCare Connect Program monitored for completion and collection for Initial HRA	OCC- Administer the initial HRA to the high risk beneficiary within 45 ~~90~~ days of a beneficiary's enrollment OCC- Administer the initial HRA to the low risk beneficiary within 90 ~~45~~ days of a beneficiary's enrollment	For OCC Initial High Risk HRA, - Achieve Collection Rate of 56%, report quarterly	Both metrics exceeded collected goal.	Continue outreach efforts.	Quarterly	
21	COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Review of Health Risk Assessments for OC New Beneficiary's	OC- Health Risk Assessment Outreach for members in the OneCare Program monitored for completion for Initial HRA	OC - Administer the Initial HRA within 90 days of beneficiary eligibility.	For OC Initial HRA - Achieve Collection Rate of 78%, report quarterly	54% collected for Q1 however, 32% of initial HRAs are still within the outreach period.	Continue monitoring and outreach efforts	Q2	

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22	COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Review of Health Risk Assessments for SPD New Beneficiary's	SPD- Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion for Initial HRA	SPD- Administer the initial HRA to the high risk beneficiary within 45 days of a beneficiary's eligibility; SPD- Administer the initial HRA to the low risk beneficiary within ~~90~~ 105 days of a beneficiary's eligibility	For SPD Initial High Risk HRA - Achieve Collection Rate of 63% report quarterly	73% combined pediatric and adult high risk HRA collected for quarter 1.	Continue outreach efforts.	Quarterly	
23	COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Annual Collection and Review of Health Risk Assessments for OCC/ OC/ SPD existing members	OCC/OC/SPD Administer the annual HRA to the beneficiary to all participants	OCC/OC/SPD Administer the annual HRA to the beneficiary to all participants	Achieve 50% Collection rate for OCC Annual, and 34% for OC Annual. No goal set for SPD.	OC annual Q1-50% (exceeds goal) OCC annual Q1 25% collected. OCC Q1 represents about 40% of all OCC members due to OC-OCC transition. This impacts outreach capacity.	Continue outreach efforts.	Quarterly	
24	COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	High ER Utilization	Evaluation and intervention for ongoing review of high ER utilizers	Identify top 10 high ER utilizers for CCN per quarter (all lines of business); Open to case management with focused group of case managers ; Regular meetings to identify causes of high utilization and effective strategies for reduction in inappropriate ER utilization	5% reduction in ER visits among intervention cohort	Q1 members identified. Goal met for quarter.	continue enrolling new cohorts and refine analysis	Q1 Met	
25	COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Review Of Member Satisfaction With CM Programs	Annual review of member feedback on the case management programs to assure high satisfaction and improved health status	Review annual satisfaction survey results, define areas for improvement and implement interventions to improve member experience with CM programs	Satisfaction with Case Management - 88%	All areas met goal for Q1 except Case Management was beneficial, which was 82%.	Continue monitoring with revised methodology.	Q2	
26	COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Coordination of CCS Medical Home and CalOptima PCP	Monitor coordination efforts between CCS Medical Home and CalOptima PCP's	Coordinated quarterly review with CCS. Establishment of pilot to address CCS questions. Root cause analysis completed.	90%	70% agreement between PCP and medical home for Q1	Implement pilot (CCS)	Q3 with quarterly review	
27	COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	HN MOC Oversight	Regular review of the Health Network's performance of MOC functions	Review of 100% of MOC files with monthly feedback provided to Health Networks	HN to achieve 80% score	One health network did not meet goal for two months	Outreach, retraining, support. Consider CAP if no improvement.	Quarterly	
28	BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up Care for Children with Prescribed ADHD Medication (ADD) Initiation Phase	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	• Continue to hold monthly BH QI work group with representation from the various departments associated with the measures • Continue to work on current intervention focus for AMM and ADD HEDIS measures • BHI has several measures that are being monitored which may also serve as opportunity for improvements	Medicaid 48.18%	HEDIS M/C 39.88% Measurement period 3/1/17 - 2/29/18; new measurement period began end of Q1, 2018	Route ADHD Provider Tip Sheet through communications for dissemination Review data for trends for top 10 providers and determine if reminder conversation is impactful approach	Q2-Q3	
29	BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	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.	• Continue to hold monthly BH QI work group with representation from the various departments associated with the measures • Continue to work on current intervention focus for AMM and ADD HEDIS measures • BHI has several measures that are being monitored which may also serve as opportunity for improvements	Medicaid 44.80%	HEDIS M/C 52.98% Measurement period 3/1/17 - 2/29/18; new measurement period began end of Q1, 2018.	Route ADHD Provider Tip Sheet through communications for dissemination Review data for trends for top 10 providers and determine if reminder conversation is impactful approach	Q2-Q3	

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30	BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM) Acute Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	• Continue to hold monthly BH QI work group with representation from the various departments associated with the measures • Continue to work on current intervention focus for AMM and ADD HEDIS measures • BHI has several measures that are being monitored which may also serve as opportunity for improvements	Medicaid 56.94% OneCare 75.00% OneCare Connect 63.45%	M/C: 55.42% - On track OCC: 64.04% - On track OC: 57.14% - At risk Measurement period: 5/1/17 - 4/30/18; **new measurement period begins Q2,** end of first month	The BHQI work group agreed to test the replication of ADHD Provider Tip Sheet for AMM as an intervention. **There is currently no active intervention for this measure**. Nationally, plans are using provider tool kits and tip sheets to highlight the intricacies of BH HEDIS measures. Refresh educational updates to providers	Q3-Q4	
31	BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM) Continutation Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	• Continue to hold monthly BH QI work group with representation from the various departments associated with the measures • Continue to work on current intervention focus for AMM and ADD HEDIS measures • BHI has several measures that are being monitored which may also serve as opportunity for improvements	Medicaid 41.12% OneCare 53.90% OneCare Connect 47.09%	**M/C: 32.48% - At risk** **OCC: 38.30% -** At risk *At risk for both MC and OCC due to measurement period already closing on 4/30/18. May not get to the intended goal. **OC: 64.29% - On track** Measurement period: 5/1/18 - 4/30/19; new measurement period begins Q2, end of first month	The BHQI work group agreed to test the replication of ADHD Provider Tip Sheet for AMM as an intervention. There is currently no active intervention for this measure. Nationally, plans are using provider toolkits and tip sheets to highlight the intricacies of BH HEDIS measures. Refresh educational updates to providers	Q3-Q4	
32	BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 30 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure - The percentage of discharges for which the patient received follow up within 30 days of discharge	OCC Quality Withold Goal 60.89%	HEDIS OCC 52.98% Measurement period 1/1/18 – 12/1/19	Continue to hold monthly meeting with MBHO FUH rate improving, continue monitoring	Q4	
33	BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 7 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure - The percentage of discharges for which the patient received follow up within 7 days of discharge	OCC Quality Withold Goal 56%	HEDIS OCC 39.88% Measurement period 1/1/18 - 12/1/19	Continue to hold monthly meeting with MBHO FUH rate improving, continue monitoring	Q4	
34	BHQIC	Quality of Clinical Care	Behavioral Health	Edwin Poon	Interdisciplinary Care Treatment Team Participation	Behavioral health services, integration and coordination of care will be monitored and measured	Monitor and identify opportunities to improve integration and coordination of care across settings and /or transitions of care through ICT/ICP	Maintain or improve the participation rate of 95% or higher for Medi-Cal, One Care and One Care Connect ICTs or ICPs completed	*Goals met Q1 2018 *65/65 for invitation /participation for OC Health Networks; and *91/91 for invitation/participation; and *6/4 for invitation/participation for OCC Health Networks *Opportunities for improvement include BH Practitioners sharing case information more frequently and/or timely with PCPs and BH Providers	*BHI updating ICT particpation form in coordination with clarified definition. This will roll out with explanation to the Health Networks and result in change of process for them. *Continue to accept ICP information and updates in lieu of presence for ICT. *Clinical staff report member information for providers unable to attend ICT	Q4	
35	BHQIC	Quality of Clinical Care	Behavioral Health	Edwin Poon	Adopt Behavioral Health Clinical Practice Guidelines	BH Clinical Practice Guidelines will be reviewed and adopted	Adoption of at least two behavioral health Clinical practice guidelines will be reviewed and adopted	Annual Adoption of BH Clinical Practice Guidelines	Completed in Q2 of 2017; Bi-annual review requirement; CPGs will go to committee again in 2019	Review posted behavioral health guidelines for any updates; adjust where indicated	Q4	
36	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	**RETIRE*** Review And Assess LTSS Hospital Admissions For Members Participating with Each Program	Member review of Hospital Admissions (for each organization/program)	Measure those members participating in each program for hospital admissions 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				

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37	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	**RETIRE*** Review And Assess LTSS Emergency Department Visits For Members Participating with Each Program	Member review of Emergency Department Visits (for each organization/program)	Measure those members participating in each program for ED Visits 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
38	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	**RETIRE*** Review And Assess LTSS Hospital Readmissions For Members Parctipating with Each Program	Members reviewed for Hospital Readmissions (for each organization/program)	~~Measure and assess hosptial readmissions~~ within 30 days for members in each program to drive interventions to minimize hospital readmissions 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
39	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	**RETIRE*** Review And Assess LTSS utilization of Long Term Care, Home and Community Based Services For Member Participating in Each Program	Members reviewed for utilization of Long Term Care, Home and Community Based Services (for each organization/program)	Measure and assess utilization of LTC, Home and Community Based Services for members in each program 1. CBAS, 2. IHSS, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
40	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Operational Performance CBAS	100 % Compliance	Timeliness of Determination Inquiry to CEDT completion	CBAS CEDT TAT Complete within 30 calendar days of request for services.	QTR 1 CBAS CEDT 100% Compliant	Continue to monitor.	On-Going	
41	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Operational Performance	Consistent application of guidelines	Inter-Rater Reliability (IRR) assessment to ensure consistent application of guidelines	Annual IRR assessment will reflect a score ≥ 90% Annual Assessment occurs in Quarter 2	N/A To complete in Q2.	LTSS Clinical staff will complete IRR testing in May 2018.	Q2 2018	
42	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Operational Performance MSSP	Ensure provision of MSSP to maximal participants (within program constraints).	Monitor New Admissions Discharges (voluntary terminations and involuntary terminations)	To be determined after establishing baseline.	QTR 1 New Admissions 33 Discharges Voluntary 9 Involuntary 23	Continue to monitor.	On-Going	
43	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Number of CBAS members transitioned to LTC.	Promote continued community placement when safe and appropriate.	Track CBAS participants who transition to LTC.	To be determined after establishing baseline.	QTR 1 Medi-Cal 9 of 2238 OCC 0 of 127	Continue to monitor.	On-Going	
44	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Ratio of average CBAS utilization (delivered) to average authorization (approved) for CBAS participation days.	Ensure appropriate level (amount) of CBAS services.	Implement processes to track authorized days versus actual participant days. Evaluate variance reasons (e.g. illness, hospitalized, vacation)	To be determined after establishing baseline.	QTR 1 89,617 Days Used of 114,631 Authorized (78.2%)	Continue to monitor.	On-Going	
45	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Overall ratio of members participating in CBAS versus potentially program-eligible members.	Promote continued community placement with HCBS when safe and appropriate.	Quarterly reporting	To be determined after establishing baseline.	QTR 1 OCC 127/984 (12.9%) Medi-Cal 2239/11,265 (19.9%)	Continue to monitor.	On-Going	
46	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Member satisfaction	Evaluate member satisfaction with LTSS programs.	Annual member satisfaction survey CBAS and LTC	To be determined after establishing baseline.	N/A To complete in Q4.	Currently analyzing data from 2017 surveys.	Q2 2018	
47	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Overall ratio of members residing in LTC versus entire OCC/SPD memberships.	Monitor impact of HCBS in promoting residence in least restrictive environment.	Quarterly reporting	To be determined after establishing baseline.	QTR 1 OCC 251/15,012 (1.57%) SPD 1876/122,775 (1.53%)	Continue to monitor.	On-Going	
48	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Number of LTC members successfully transitioned out to a lower LOC/community.	Monitor impact of focused transition efforts supporting member transitions to the community.	Quarterly reporting	To be determined after establishing baseline.	QTR 1 103 of 5,319 members	Continue to monitor.	On-Going	
49	LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	MSSP Transition Planning	Coordinated transition of all MSSP members into new benefit model.	Transition planning involving DHCS, CDA, internal and external stakeholders.	1/1/2020 is scheduled transition date.	Meetings with internal stakeholders held.	Continue communication and coordination with DHCS and CDA.	Q1 2020	
50	LTSS-QISC	Quality of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	***RETIRE:** CBAS Member Satisfaction (See # 46)	Monitor and/or improve member satisfaction in CBAS	a) Measure, assess and identify areas for improvement through the distribution of a member satisfaction survey. b) Implement interventions to assure high member satisfaction	90% of the Centers will achieve an overall satisfaction rating 3 or greater	2017 Survey data has been tallied, and written responses have been captured. 2018 survey tool has been finalized, and has been submitted to Communications for approval.	2017 - 1)Data analysis, 2)Sharing data with CBAS centers, 3)Presenting data to LTSS QIS Committee 2018 - 1)Have the survey tool translated to the threshold languages, 2)Determine the methodology for the survey.		

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51	LTSS-QISC	Quality of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	***RETIRE:** SNF Member Satisfaction (See #46)	Monitor and/or improve member satisfaction in SNF/LTC facilities	a) Measure, assess and identify areas for improvement through the distribution of a member satisfaction survey. b) Implement interventions to assure high member satisfaction	90% of the facilities will achieve an overall satisfaction rating 3 or greater	2017Survey data has been tallied, and written responses have been captured. Data analysis is in process. 2018 survey tool has been finalized, and has been submitted to Communications for approval.	2017 - 1)Data analysis, 2)Sharing data with LTC facilities, 3)Presenting data to LTSS QIS Committee 2018 - 1)Determine the methodology for the survey.		
52	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) HbA1c Testing	Outreach to members who are due for HbA1c testing. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives.	Medicaid 87.1% OneCare 93.82% OneCare Connect 91.73%	**March 2018 Prospective Rates:** Medicaid 42.38% OneCare 35.84% OneCare Connect 42.54% - Rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/educators.	12/31/2018	
53	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) HbA1c Poor Control (>9.0%)	Outreach to members who have poor or uncontrolled HbA1c levels. For the CCN population, targeted outreach to high volume providers via medical director outreach. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid 29.07% OneCare 20% OneCare Connect 27%	**March 2018 Prospective Rates:** Medicaid 74.34% OneCare 83.87% OneCare Connect 81.65% - Rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/educators.	12/31/2018	
54	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) HbA1c Control (<8.0%)	Interventions may include; targeted mailings with educational materials. Members are identified and enrolled in the disease management program with opt-out option.	Medicaid 59.12% OneCare 69.71% OneCare Connect 64.72%	**March 2018 Prospective Rates:** Medicaid 21.34% OneCare 13.98% OneCare Connect 15.83% - Rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/educators.	12/31/2018	
55	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) Eye Exam	Targeted outreach to members who are due for a diabetic eye exam. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid 65.83% OneCare 81% OneCare Connect 81%	**March 2018 Prospective Rates:** Medicaid 30.52% OneCare 31.90% OneCare Connect 39.28% - Rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) targeted mailings, 3) educational outreach by health coaches/educators.	12/31/2018	
56	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) Medical Attention for Nephrology	Targeted outreach to members who are due for a screening. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid 91.24% OneCare 94% OneCare Connect 96%	**March 2018 Prospective Rates:** Medicaid 69.64% OneCare 67.74% OneCare Connect 78.8% - Rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) targeted mailings, 3) educational outreach by health coaches/educators.	12/31/2018	
57	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) Blood Pressure Control (<140/90 mm Hg	Outreach to diabetic members with high blood pressure. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid 72.24% OneCare 80.12 OneCare Connect 70.83%	**March 2018 Prospective Rates:** Medicaid 9.61% OneCare 14.34% OneCare Connect 11.44% - Rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/educators.	12/31/2018	

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58	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	All-Cause Hospital Readmissions (PRC)	Continue to implement the Transition of Care program; focus on the health coaching intervention.	OneCare 6% OneCare Connect 9%	**March 2018 Prospective Rates:** OneCare 9.09% OneCare Connect 8.44% - Rates are higher when compared to same time last year.	Continue to implement the Transition of Care program; focus on the health coaching intervention. Working on improving data process and validating results on a monthly basis	12/31/2018	
59	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC) Timeliness of Prenatal Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July, 2018.	Medicaid 86.79%	**March 2018 Prospective Rates:** Medicaid 75.34% - Rate is higher when compared to same time last year.	Continue with targeted prenatal and postpartum mailings until the launch of the Bright Steps program. Implement the member incentive program in June, 2018.	Ongoing	
60	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC) Postpartum Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July, 2018.	Medicaid 69.44%	**March 2018 Prospective Rates:** Medicaid 39.47% - Rate is higher when compared to same time last year.	Continue with targeted prenatal and postpartum mailings until the launch of the Bright Steps program. Implement the member incentive program in June, 2018.	Ongoing	
61	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS) Combo 3	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 74.39%	**March 2018 Prospective Rates:** Medicaid 40.87% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	12/31/2018	
62	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS) Combo 10	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 37.23%	**March 2018 Prospective Rates:** Medicaid 24.42% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	Q4, 2018	
63	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Lower Back Pain (LBP)	Provider education and outreach	Medicaid 74.40%	**March 2018 Prospective Rates:** Medicaid 75.89%	Developing a news article for Provider Update and/or targeted mailings to Providers.	Q4, 2018	
64	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 76.17%	**March 2018 Prospective Rates:** Medicaid 32.74% - Rate is higher when compared to same time last year	Implement PIP activities focusing on targeted provider offices. Develop/Update educational materials for members to be included in newsletters.	Q4, 2018	
65	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP) 12-24 months	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 95.7%	**March 2018 Prospective Rates:** Medicaid 70.60% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	Q4, 2018	
66	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP) 25 months - 6 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 87.87%	**March 2018 Prospective Rates:** Medicaid 37.47% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	Q4, 2018	
67	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP) 7-11 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 90.77%	**March 2018 Prospective Rates:** Medicaid 82.18% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	Q4, 2018	
68	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP) 12-19 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 89.52%	**March 2018 Prospective Rates:** Medicaid 78% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	Q4, 2018	
69	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Cervical Cancer Screening (CCS)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 58.48%	**March 2018 Prospective Rates:** Medicaid 44.57% - Rate is higher when compared to same time last year	Implement the member incentive program in June, 2018. Plan targeted mailings.	12/31/2018	

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70	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites, target mailings, incentives, and facets pop-ups.	Medicaid 80.64%	**March 2018 Prospective Rates:** Medicaid 15.69% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	Q4, 2018	
71	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Care Visits in first 15 months of life (W15)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites, target mailings, incentives, and facets pop-ups.	Medicaid 56.11%	**March 2018 Prospective Rates:** Medicaid 12.61% - Rate is higher when compared to same time last year	Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	Q4, 2018	
72	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Appropriate Testing for Children with Pharyngitis (CWP)	Provider outreach at PCP sites, Target urgent care centers	Medicaid 67.15%	**March 2018 Prospective Rates:** Medicaid 53.08% - Rate is higher when compared to same time last year	Focus is on Urgent Care centers. Purchasing kits to distribute to CCN contracted Urgent Care centers and some targeted high-volume offices.	Q2, 2019	
73	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Colorectal Cancer Screening (COL)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screenings event, target mailings, incentives, and facets pop-ups.	OneCare 63% OneCare Connect 63%	**March 2018 Prospective Rates:** OneCare 39.88% OneCare Connect 35.41% - Rates are higher when compared to same time last year.	Targeted mailing to OC and OCC members in Q2, 2018.	Q3, 2018	
74	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA) Medication Review	Targeted outreach to providers; obtain ICP for each members	OneCare 88% OneCare Connect 79%	**March 2018 Prospective Rates:** OneCare 6.17% OneCare Connect 6.84% - Rates are lower when compared to same time last year for the OC population but higher for the OCC population.	Case Management to continue outreaching and obtaining ICPs. There is also the OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).	Q4, 2018	
75	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA) Functional Status Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare 67% OneCare Connect 67%	**March 2018 Prospective Rates:** OneCare 4.87% OneCare Connect 5.65% - Rates are lower when compared to same time last year for the OC population but higher for the OCC population.	Case Management to continue outreaching and obtaining ICPs. There is also the OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).	Q4, 2018	
76	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA) Pain Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare 94% OneCare Connect 80%	**March 2018 Prospective Rates:** OneCare 6.17% OneCare Connect 6.43% - Rates are lower when compared to same time last year for the OC population but higher for the OCC population.	Case Management to continue outreaching and obtaining ICPs. There is also the OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).	Q4, 2018	
77	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Breast Cancer Screening (BCS)	Targeted outreach to members who are due for a screening. Interventions may include; mobile mammography event, target mailings, incentives, and facets pop-ups.	Medicaid 65.52% OneCare 78% OneCare Connect 78%	**March 2018 Prospective Rates:** OneCare 53.18% OneCare Connect 49.48% - Rates are higher when compared to same time last year.	Implement the member incentive program in June, 2018. Plan mobile mammography (Alinea) event with Community Relations for quarter 2-4, 2018	12/31/2018	
78	QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	Provider education via the AWARE Toolkit.	Medicaid 24.91%	**March 2018 Prospective Rates:** Medicaid 26.31% - Rates are higher when compared to same time last year.	Send AWARE toolkit in Q4, 2018.	Ongoing	

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79	COPHS	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour, Pharm.D.	Improve identified HEDIS Measures	Statin Therapy for Patients with Cardiovascular Disease (SPC)	Physician notification faxes	**MCAL** Statin therapy 75.85% Adherence 73.43% **OCC** Statin therapy 73.56 Adherence 71.14% **OC** Denominator too small last year to set goal	**MCAL:** faxes sent to 188 providers for 453 members **OCC:** faxes sent to 94 providers for 117 members **OC:** faxes sent to 9 providers for 9 members **Failed faxes:** none **Barriers:** -HEDIS registry data refreshes in January, so intervention data has to be tweaked to take into account end of the year pharmacy claims for statins (more manual) -Some members do not have PCPs assigned **Provider responses:** -Provider states member is already prescribed statin despite letters addressing adherence to statin -Member can't tolerate a moderate/high potency statin or member can't use a statin at all (member removed from faxed interventions) **2017 Final HEDIS rates:** **MCAL:** Statin therapy 73.64%; Adherence 71.91% **OCC** Statin therapy 70.45%; Adherence 70.41% **OC** Statin therapy 45.45%; Adherence 100%	2Q18 faxes	Jun-18	
80	COPHS	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour, Pharm.D.	Improve identified HEDIS Measures	Statin Therapy for Patients with Diabetes (SPD)	Physician notification faxes	**MCAL** Statin therapy 66.31% Adherence 67.76% **(5/2/18- OC/OCC was added to goal/Timeline)** **OCC** Statin therapy 73.83% Adherence 74.75% **OC** Statin therapy 67.37% Adherence 77.13%	**MCAL:** faxes sent to 600 providers for 8781 members **OCC:** faxes sent to 374 providers for 889 members **OC:** faxes sent to 33 providers for 36 members **Failed faxes:** 25 failed faxes for 16 unique prescribers 370 members (across all LOBs) **Barriers:** -HEDIS registry data refreshes in January, so intervention data has to be tweaked to take into account end of the year pharmacy claims for statins (more manual) -Some members do not have PCPs assigned -Bad faxes **Provider responses:** -Provider states member is already prescribed statin despite letters addressing adherence to statin **2017 Final HEDIS rates:** **MCAL** Statin therapy 65.44%; Adherence 65.28% **OCC** Statin therapy 73.25%; Adherence 71.98% **OC** Statin therapy 66.18%; Adherence 76.67%	2Q18 faxes	Jun-18	
81	COPHS	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour, Pharm.D.	Improve identified HEDIS Measures	Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	Physician notification faxes	**MCAL:** 80.95% **(5/2/18- OC/OCC was added to goal/Timeline)** **OCC:** 96.1% **OC:** Denominator too small last year to set goal	**MCAL:** faxes sent to 41 providers for 51 members **OCC:** faxes sent to 2 providers for 2 members **OC:** none **Failed faxes:** none **Barriers:** -HEDIS registry data refreshes in January, so intervention data has to be tweaked to take into account end of the year pharmacy claims for beta blockers -Failed faxes require manual intervention **2017 Final HEDIS rates:** **MCAL** 79.79% (goal 83.06%); below 50th percentile **OCC** 96.97% (goal NA); above 75th percentile **OC** NA (denominator too small to report)	2Q18 faxes	Jun-18	

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82	COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Initial Health Assessment Completion Rate	To assure all new members are connected with a PCP and their health risks are assessed	IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed within 120 days of enrollment; Reports will be available for Health Networks on IHA/SHA completion; Facility Site Reviews will review a sample of medical records for compliance with completing appropriate age level IHA/SHA; If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief Intervention, and Referral to Treatment)	Improve plan performance over 2017 by 5%	IHA Completion Rates* Q1 2017 - 47.52% Q1 2018 - 43.22% *Data as of 4/30/18; IHA performance calculated as fully met + partially met (*Fully Met* Evidence of an IHA visit and SHA within 120 days of member effective date; *Partially Met* Evidence of an IHA visit or SHA within 120 days of member effective date) Presented IHA Chart Audit findings for CalOptima Community Clinics at Quality Forum (March 2018) and Health Network Forum (April 2018). Random sampling of IHAs completed January 1, 2017 -May 31, 2017 at community clinics. Summary for Chart Audit identified the following % compliance in chart documentation (medical records audited -734)- *Comprehensive History 83.92% *Preventive Services 88.69% *Comprehehsive Physical/Mental Status Exam 78.07% *Diagnoses Plan of Care 94.14% *IHEBA/SHA 48.09%	*Review Place of Service in existing IHA report methodology- may need to remove urgent care and emergency department *Send desktop for IHA chart audit to Health Networks *Prepare for IHA chart audit with Community Clinics in July 2018	12/31/2018	
83	COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Review of Disease Management Programs	Disease Management activity reviewed to assess clinical care delivered to members with Asthma, Diabetes and Heart Failure	Develop DM Program interventions to help improve HEDIS measures such as AMR, MMA, MPM, CBP; Assure DM programs are implemented across all populations; Conduct annual member satisfaction of DM programs; Evaluate the overall effectiveness of the Program-Participation Member Rates, ED, IP and RX related utilization	Improve program participation rates over 2017 by 3% Reduce ED and IP rates for program participants by 3% Increase member satisfaction with DM Programs to 90%	**March 2018 Medi-Cal Prospective Rates:** AMR 5-11 79.95% 75th percentile MMA 5-64 PENDING HbA1c Testing 42.38% 25th Percentile - ↑ 16% since Feb 2018 HbA1c Poor Control 25th Percentile - Improvement, ↓ 9% from Feb 2018 (lower rate is better) Eye Exam 30.52% - 3% ↑ from Feb 2018 - 25th Percentile Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBs 48.37% - ↑ 16% since Feb 2018 - 25th Percentile **March 2018 OCC Prospective Rates:** HbA1c Testing 42.54% ↑ 17% from Feb 2018 - < 25th Percentile Controlling High Blood Pressure Waiting for Final rates - chart review 2017 DM Satisfaction -98.4% actively managed DM members are overall satisfied with CalOptima's DM Programs	*Continue efforts to redesign methodology in Guiding Care *Continue efforts to improve member triage and referral to staff (Round Robin) *Implement targeted campaigns for MMA and repeat member incentive for Diabetes eye exam	12/31/2018	
84	COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Implementation of Population Health & Wellness Programs	Expand child and adolescent components for the Shape Your Life/Weight Management Program; Implement Weight Watchers benefit for Shape Your Life CalOptima Medi-Cal members age 15 years or greater; Design and implement a comprehensive Perinatal Health Program	Establish program goals, objectives and interventions; Develop clinical and operational components to expand the reach and capability; Identify program resources and vendor support (Provider, Health Ed/RD linkages, Community Based Organizations); Implementation of revised program design	Implement revised program design-2018; Evaluate progress semi-annually	*Contracts established for Shape Your Life (SYL) childhood obesity program *CME with emphasis on childhood obesity scheduled for May 8th 2018	*Award vendors for the Perinatal Support Services program *Initiate contracts in support of RFP awards	12/31/2018	
85	COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Adopt Medical Clinical Practice Guidelines	Clinical Practice Guidelines will be reviewed and adopted	Adoption of Clinical Practice Guidelines, as least three (3) will be reviewed and adopted (linked to DM Diabetes, Asthma, CHF)	CPG's reviewed and adopted every two years	CPGS approved in July 2017	Next review in 2019	Jul-17	
86	QIC	Quality of Clinical Care	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	**OneCare CCIP:** Diabetes to improve HBA1C Testing, Targeted mailings to members; Outreach to health networks; provide monthly Prospective Rates and member detail information to health networks	Goal TBD/ Starting January 2018	After conversion from OC QIP into OC CCIP, DM in planning stage to incorporate telephone outreach to identified members needing A1C and DM health coaching to improve self-management.	Health Coach calls to initiate in May 2018	12/31/2018	

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87	QIC	Quality of Clinical Care	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	**OneCare Connect CCIP:** Heart Health	Goal TBD/ Starting January 2018	Pilot transitions of care program developed for CCN Heart Failure members with admission. Collaboration between DM, UM and Pharmacy departments to implement phone intervention within 3 days of hospital discharge to help prevent readmission within 30 days.	Program scheduled for launch in May 2018 pending ability to obtain Medication List.	12/31/2018	
88	QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	**OneCare Connect QIP** To Improve 30-day Readmission Rate <16.8% ; Transition of Care program; health coach outreach	**OneCare Connect QIP** To Improve 30-day Readmission Rate <16.8%; Transition of Care program; health coach outreach	TOC team working on addressing data issues and improving processes.	Continue to implement the Transition of Care program; focus on the health coaching intervention. Working on improving data process and validating results on a monthly basis. NOTE We are working on the data issues and validating the current information that we are receiving from Guiding Care. That is why this PIP is yellow.	12/31/18	
89	QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	**OneCare QIP (NEW)** Focus on Chronic Conditions (TBD)	**OC QIP (NEW)** Improvement hypertension care for OC members through caregiver support. A 3-year cycle; annual submissions.	DM will be implementing the intervention starting Q3.	Disease Management and Quality Analytics are developing new program. DM will implement the interventions.	12/31/20	
90	QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	**Medi-Cal PIP:** Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c >9%) residing in Santa Ana, CA. (Focus on health disparities); Targeted provider outreach in the CCN network; Increase referrals and participation in CalOptima' Disease Management program; Educational classes	**PIP** Reduce the Poor Control (HbA1c >9) targeted group down from 62.5% to 52.31%	Currently in Module 3 phase	Submit Module 3 of the PIP on 5/15/18 to DHCS for approval. On Track	Est. June, 2019	
91	QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	**Medi-Cal PIP:** Improving Adult's Access to Preventive/Ambulatory Health Services Ages 45-64 years	Improving Adult's Access to Preventive/Ambulatory Health Services Ages 45-64 years PIP Goal 82.49%	Currently in Module 3 phase	Submit Module 3 of the PIP on 5/15/18 to DHCS for approval. On Track.	Est. June, 2019	
92	QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	**OneCare Connect PIP:** Improving rate of completed Individualized Care Plan Completed for members and improve rate of Members with Documented Discussions of Care Goals	PIP Member with an Individualized Care Plan Completed/Members with Documented Discussions of Care Goals (OCC) 1) CA 1.5 – Members with an Individualized Care Plan Completed. Year 1 Goal High Risk 79.9%; Low Risk 71% 2) CA 1.6 – Members with Documented Discussions of Care Goals. Year 1 Goal 77.91%	Submitted plan proposal on 4/6/18	CalOptima submittedDHCS provided feedback to plan proposal. Resubmission due 5/18/18. Pending feedback and approval from DHCS/CMS.	12/31/2019	

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93	QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	**OneCare Connect PDSA** - Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents (LTC - OCC); Treatment in Place training to targeted facility sites and Follow up with targeted facility sites by CalOptima nurses	**SMART Objective 1:** By 6/30/2018, CalOptima will offer enhanced care coordination to all OCC CCN LTC members with ≥ two (2) acute admissions within the last rolling 12 months. **SMART Objective 2:** By 9/30/2018, the rolling 12-month average acute admissions represented by OCC CCN LTC members with multiple admissions, 2.76 admissions per member per year at 2017 baseline, will decrease to ≤2.45 admissions per member per year **SMART Objective 3:** By 3/31/2019, the overall rolling 12-month average ratio of acute admissions represented by all OCC CCN LTC members, 0.88 admissions per member at 2017 baseline, will decrease to ≤0.79 admissions per member per year.	Submitted Cycle 4 PDSA update on 4/30/18. Concluded the Treatment in Place (TIP) intervention for Cycle 1-4 of this PDSA project on 3/31/18.	Starting Q2, 2018, CalOptima is implementing a new intervention. Title Increasing post-hospitalization coordination and support among OneCare Connect Long Term Care members in the CalOptima Community Network to decrease acute readmission rates. On Track.	Ongoing; PDSA cycles are determined by CMS	
94	UMC	Safety of Clinical Care	Pharmacy	Kris Gericke	Utilization of Opiod Analgesics	Promote optimal utilization of opioid analgesics	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics. Prescriber monitoring and education	Reduction in opioid analgesic overutilization as measured by number of prescriptions and quantity per prescription for short-acting opioid analgesics	The average number of Rxs PMPM for opioid analgesics decreased from 0.0253 to 0.0245 from 4Q17 to 1Q18 (3.2% decrease). The average quantity per Rx for short-acting opioid analgesics decreased from 58.3 to 57.6 from 4Q17 to 1Q18 (1.2% decrease).	Implement additional formulary quantity limits per P&T Committee approval. Continue with quarterly prescriber report cards.	Jul-18	
95	UMC	Safety of Clinical Care	Pharmacy	Kris Gericke	Pharmacy Benefit Manager (PBM) Oversight	Provide ongoing monitoring of the PBM contract performance guarantees	Review and report on clinical and service metrics for MedImpact as it relates to performance guarantees	PBM Performance Guarantees met per the PBM Services Agreement	4Q17 Performance Guarantees met.	Continue to monitor quarterly reports.	Jun-18	
96	COPHS	Quality of Clinical Care	Pharmacy	Nicki Ghazanfarpour, Pharm.D.	new WP element added 5/2018	Appropriate Medication Utilization	Prescriber and Pharmacy Interventions	Focused projects completed in March 2018	**Residency projects:** **Inappropriate PPI use in the elderly MCAL CCN population:** -Review of 7 265 pharmacy claims for PPIs -Applied evidence-based criteria to members to identify those with a lack of documentation supporting chronic use n=64; 63 of 64 interventions via fax were successfully confirmed -At 120 day post intervention mark 54 members continued to meet eligibility criteria -2 waves of medication review interviews were conducted (initial 60 day) and the final review was completed at 120 days -Final results: 17 members successfully deprescribed the PPI (16 discontinued 1 tapered down; results statistically significant) **Promotion of pharmacist furnished naloxone via partnership with CVS pharmacy:** -4 month study identifying top 15 CVS pharmacies with our Medicare members who meet CDC high risk criteria for opioid use where naloxone co-prescribing is recommended -Intervention: pharmacy visit naloxone tool kit for pharmacists (billing counseling information talking points) monthly high risk member lists pre and post pharmacist survey -CVS interventions: stickers placed on opioid RXs naloxone conversation tracking pharmacist -132 unique members met criteria -Baseline: no naloxone prescriptions were written by a pharmacist -Result: 65 members had a naloxone conversation initiated by a pharmacist 19 members had the stickers applied to their prescriptions and 13 members had been successfully dispensed naloxone prescribed by a pharmacist -Pre and post survey responses: consistent knowledge about how to identify high risk patients comfort level and awareness improved; post survey indicated concerns about having enough time to engage members for interventions	Results to be presented in formal presentation at residency conference in May 2018. Future pilot projects to be determined. Residency year starts over July 2018, new projects to be determined.	N/A	
97	CPRC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Katy Noyes	Providers Shall Have Timely And Complete Facility Site Reviews	To assure all new and re-credentialed providers are compliant with FSR/MRR/PAR requirements	Facility Site Reviews (FSR), Medical Record Reviews (MRR) and Physical Accessibility Review Surveys (PARS) are completed as part of initial and re-credentialing cycles; Report of FSR/MRR/PARS activity to CPRC	100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes, measured as 100% Full Scope Periodic Audits completed within three years from the last FSR/MRR and PARS.	The goal is measured as the number of Full Scope Period audits completed within three years of previous audit. In Q1, 17 Full-Scope audits were overdue in Q1. The FSR/MRR team has been short staffed since November, which has also contributed to the overdue audits. Other results; 10 Initial FSR's completed, 67 Full Scope FSR/MRR completed. One MRR failed 80% threshold. Corrective Action Plan issued, and panels were closed until corrected. 16 CE CAPS, 30 FSR CAPS and 18 MRR CAPS with a total of 64 CAPS issued in Q1. 151 PARS Completed achieving 54% BASIC accessibility for sites measured.	Working on process to reduce the # of overdue FSR/MRR. In the process of certifying one FSR Nurse and hiring another. Will increase visibility and communication when audits are overdue. Also, working to improve CAP closure timeframes. Only 67% of CE CAPS issued were completed within the 10 day TAT timeframe.	6/30/2018	

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98	CPRC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	Follow-up on Potential Quality Of Care Complaints	To assure patient safety and enhance patient experience by timeliness of clinical care reviews	QI Nurse Specialists and Medical Directors review cases and provide determination; Report all case results to CPRC for discussion; Present cases that have a severity rating of 1 (one) or higher will be presented to CPRC for action; Follow through on Medical Director determination, when applicable, to ensure closure and compliance of all cases; Conduct a PQI trend analysis at least two times a year. Review GARS and PQI's twice annually for trends by practitioner.	Achieve a turnaround time of 90 days on 90% of cases received; Review data for trends and patterns by practitioner. Take appropriate actions for outliers.	In Q1, 2018, 43% of the cases were closed in 90 days or less. On average, cases took 107 days to close. This was due in part to changes in the number of cases referred to QI in Q4 2017. We had 376 cases referred in Q3 and 680 cases referred in Q4. We implemented a triage process at the end of Q1 to identify cases that are quality of service rather than quality of care, which reduces the workload for the team. Also have requested that Altruista elevate an improvement in our electronic system, Guiding Care, so that the medical directors can begin using the system.	Continue to monitor the TAT, and work with Alturista to implement the system improvement.	6/30/2018	
99	LTSS-QISC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	CBAS Quality Monitoring	Review CBAS quality monitoring of services provided	a) Continue to assess compliance of contracted CBAS Centers. Report to LTSS QIS Subcommittee. b) Continue to review Incident and Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted CBAS centers will be audited at least annually against the audit performed by CDA. b) All (100%) CAPs generated as a result of the audit will be returned by the due date. c) The number of CBAS centers receiving a CAP will be reduced to 75% in 2018, down from 93% in 2017. d) All (100%) Incident and Critical Incident reports will be reviewed for Potential Quality of Care issues	Two CBAS centers received on-site audits in Q1; both centers received a Corrective Action Plan (CAP). One center received additional monitored visit (from annual audit visit) due to customer service complaint; no CAP issued at this time. Two outstanding CAPs from Q4 2017 were completed and returned. One new CBAS center was contracted, for a total of 32 centers. 46 incidents were reported, 2 of which were critical. No Potential Quality of Care issues with any of the reported incidents.	Continue on-site monitoring of centers. Continue reivewing incident reports for PQI issues. Track and trend incident reports.	12/31/2018	
100	LTSS-QISC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	SNF/LTC Quality Monitoring	Review SNF/LTC quality monitoring of services provided	a) Continue to assess compliance of contracted SNF/LTC Facilities. Report to LTSS QIS Subcommittee. b) Continue to review Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted SNF/LTC Facilities will be audited at least annually against the audit performed by DHCS. b) All (100%) CAPs generated, as a result of the audit, will be returned by the due date. c) The number of SNF/LTC Facilities receiving a CAP will be below 10%. d) All (100%) Critical Incident reports will be reviewed for Potential Quality of Care issues.	18 NF were audited in Q1. One CAP was generated and returned. There were 5 Critical Incidents reports; 4 of which became PQIs.	Continue on-site monitoring of NFs. Continue reivewing critical incident reports for PQI issues. Track and trend incident reports.	12/31/2018	
101	MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Rating of Health Plan	Implement CG-CAHPS to obtain provider level specific member experience data. Utilize results from CalOptima's CG-CAHPS survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan. Contract with vendor to implement Provider Coaching to improve provider satisfaction and overall member experience.	Adult Medicaid 2.43 (50th Percentile) Child Medicaid 2.57 (50th Percentile) OneCare Medicare 86% (CMS 4 star goal) OneCare Connect Medicare 86% (CMS 4 star goal)	One new CBAS contract	Field CAHPS Surveys. Provider shadow coaching and training/workshops for physicians, office managers and staff.	Q2 and Q3	
102	MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	Adult Medicaid 2.28 (25th Percentile) Child Medicaid 2.37 (25th Percentile) OneCare Medicare 82% (CMS 3 star goal) OneCare Connect Medicare 82% (CMS 3 star goal)	Total Centers count 32	Contract with a new vendor to field Timely Access Survey. Issue Corrective Action Plans to HN with areas of non-compliance.	Q2 and Q3	

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#	Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
103	MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of timely access and appointment availability standards will improve rating of Getting Care Quickly.	Adult Medicaid 2.33 (25th Percentile) Child Medicaid 2.54 (25th Percentile) OneCare Medicare 79% (CMS 4 star goal) OneCare Connect Medicare 76% (CMS 3 star goal)		Contract with a new vendor to field Timely Access Survey. Issue Corrective Action Plans to HN with areas of non-compliance.	Q2 and Q3	
104	MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service. Contract with vendor to implement Provider Coaching for Customer Service staff.	Adult Medicaid 2.54 (50th Percentile) Child Medicaid 2.50 (25th Percentile) OneCare Medicare 89% (CMS 3 star goal) OneCare Connect Medicare 89% (CMS 3 star goal)	46 incidents reported, 2 of which were critical. No Potential Quality of Care issues.	Field CAHPS Surveys. Provider shadow coaching and training/workshops for physicians, office managers and staff.	Q2 and Q3	
105	MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Care Coordination	Provider and office staff in-service on best practices to better coordinate care for members will improve rating on Care Coordination.	Adult Medicaid 2.34 (25th Percentile) Child Medicaid 2.36 (25th Percentile) OneCare Medicare 85% (CMS 3 star goal) OneCare Connect Medicare 85% (CMS 3 star goal)	2018 Scores not yet available. 2017 Scores OC 82% (1 star) OCC 82.1% achievement score (baseline)	Field CAHPS Surveys. Identify member pain points in regards to care coordination. Initiatives to be developed through the Member Experience Sub-Committee	Q2 and Q3	
106	MEMX	Quality of Service	Customer Service	Belinda Abeyta/ Albert Cardenas/L. Nguyen	Customer Service First Call Resolution	Gather data and information from members after interface with Customer Service to assure expectations/reason for call was resolved	Monitor port call information and determine key strategies to assure first call resolution/member satisfaction with customer service	85% of calls resolved at first call (Medi-Cal, OC.OCC)	QI First Call Resolution 85%. Target met. (MC) First Call of Resolution - 88.6 %/ 86.6 % of Member Calls Resolved the First Time the Member Calls (OC,OCC)	Target met fror both MC, OC, OCC	N/A	
107	MEMX	Quality of Service	Customer Service	Belinda Abeyta/ Albert Cardenas/L. Nguyen	Customer Service Access	Customer Service call lines evaluated for average speed to answer; Customer Service call line evaluated for call abandonment rate	Customer Service lines monitored for average speed to answer; Customer service lines monitored for abandonment rate	ASA 30 Seconds <5% First Call Resolution 85%	**MC:** Q1 ASA 35 seconds. Target not met. Q1 Abandonment rate 2.5%. Target met. *Expected in Q1 peak call volume *Enhancements to CSR grievance categorization and documentation process lead to 17% increase in average handle for each call in Q1 2018 (9 59 per call) vs. 2017 (8 32 per call) *Call center staffing resources not adequate for increase in call volume and avg handle time demands. **OC/OCC:** * Met the Goal of <30 seconds, 20 OC/OCC * Abandonment rate was to not exceed 5%, 3.9% for OC/OCC	**MC** *Training of staff to increase efficiency and reduce handle time of each call. *Review of call center scripting to reduce documentation fields in templates. *Actively recruiting to fill all open positions. **OC/OCC** * Continue monitoring	Training/ recruiting of staff and improvements to CSR documentation template are ongoing goals.	
108	MEMX	Quality of Service	GARS	Ana Aranda/ Esther Okajima	Review and Report GARS for all Lines of Business. Include review of quality issues (QOC, QOS, Access) related to member experience.	Global review of member "pain points"; assure appropriate actions are taken to assist the member experience, and present data to the Member Experience Committee and QIC	a) Quarterly review of all GARS data to identify issues and trends; including Health Network b) Implement any necessary corrections c) Review health network quarterly totals of grievances d) Conduct causal analysis and determine plan of action for "pain points" that affect member experience	Meet GARS Regulatory Turnaround Times 100%. Improve member experience as measured by improved CAHPS scores.	We are in the process of reviewing GARS data from a quality perspective.	Complete and report results for Q1 and Q2.	Q2, 2018	

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109	MEMX	Quality of Service	Pharmacy	Kris Gericke	Member Accesssing Pharmacy Benefit Information	Maintain member access to their pharmacy benefit and the operations of network pharmacies through the CalOptima website, or through telephone communication with CalOptima Customer Service staff	Monitor and annually report requirements for NCQA Member Connection 4 Pharmacy Benefit Information Standards	Via the CalOptima website Members are able to -Submit Prior Authorization requests; -Conduct network pharmacy proximity searches based on zip code; -Find information on potential drug-drug interactions, common side effects and significant risks, and availability of generic substitutes; and -Receive responses to pharmacy inquiries within twenty-four (24) hours (or next business day).	1Q18 MEM 4 website access testing passed all elements.	Continue to monitor quarterly reports.	Jul-18	
110	MEMX	Network Adequacy	Customer Service/ Network Mangement	Belinda Abeyta/ Jennifer Bamberg	Notification to Member when Practitioners Terminate.	Members are notified when Practitioners Terminate.	Termination of Practitioners is monitored through monthly CT forms that are submitted to PDMS. 1) Members are notified of terminated pracitioners with 30 days from when CalOptima is notified 2) Network is monitored to determine if adjustments to network are necessary.	Notification to members are within 30 days of notification to CalOptima 85% of the time.	Goal was met at 100% for member notification within 30 days of provider termination.	Cotinute to monitor and report.	Q2	
111	MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care non-urgent primary care appointments	1. Non-urgent primary care appointments within 10 business days of request	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment 90% minimum performance level	2018 Scores not yet available. For 2017 1) Met 92.7%	Contract with a new vendor to field Timely Access Survey. Issue Corrective Action Plans to HN with areas of non-compliance.	Q2 and Q3	
112	MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of primary care practitioners (min. provider ratios)	Primary care practitioner availability (min. provider ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS.. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies GG.1600 and MA.7007	Met for all lines of business	Continue to monitor	Q2	
113	MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of primary care practitioners (geographic distribution)	Primary care practitioner availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies GG.1600 and MA.7007	Met for all lines of business	Continue to monitor	Q2	

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#	Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
114	MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of specialty practitioners (min. provider ratios)	High volume and high impact specialty availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS.. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies GG.1600 and MA.7007	Met for all lines of business	Continue to monitor	Q2	
115	MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of specialty practitioners (geographic distribution)	High volume and high impact specialty availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies GG.1600 and MA.7007	Met for MC and OCC. OC preliminary HSD submission to CMS indicates possible risk with Occupational Therapy.	Outreach to HNs for their full roster of Occupatiional Therapists. If roster is not sufficient, talk to HN about recruiting more Occupational Therapists.	Q2	
116	MEMX	Network Adequacy	Quality Analytics	Marsha Choo/ Edwin Poon	Review of availability of behavioral health practitioners (min. provider ratios)	Behavioral Health practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS.. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies GG.1600 and MA.7007	Met for all lines of business	Continue to monitor	Q2	
117	MEMX	Network Adequacy	Quality Analytics	Marsha Choo/ Edwin Poon	Review of availability of behavioral health practitioners (geographic distribution)	Behavioral Health practitioner availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies GG.1600 and MA.7007	Met for all lines of business	Continue to monitor	Q2	
118	MEMX	Network Adequacy	Pharmacy	Kris Gericke	Network Pharmacy Access	Network pharmacy availability (geographic distribution) is measured and assessed to meet the standard	Quarterly GeoAccess report	Pharmacy Network Access Requirements -At least ninety percent (90%) of Members, on average, in urban areas live within two (2) miles of a Participating Pharmacy; -At least ninety percent (90%) of Members, on average, in suburban areas live within five (5) miles of a Participating Pharmacy; and -At least seventy percent (70%) of Members, on average, in rural areas live within fifteen (15) miles of a Participating Pharmacy	4Q17 network access requirements met.	Continue to monitor quarterly reports.	Jun-18	
119	CPRC	Network Adequacy	Quality Improvement	Esther Okajima/ Melinda Enos	Credentialing Of Provider Network Is Monitored	Credentialing program activities monitored for volume and timeliness	New applicants processed within 180 calendar days of receipt of application; Report of initial credentialing file activity to CPRC	90% of initial credentialing applications are processed within 120 days of receipt of application	In Q1, 89 initial files were completed were approved. 100% HDO initial files were completed within 120 days. However only 56% of the initial files were completed in less than 120 days.	Files that take greater than 120 days to complete are often due to difficulty in otaining information from the provider. There has been an increase in processing time due to the 20% increase in volume of both initial and recred files. Will continue to work towards reducing TAT when processing files.	6/30/2018	

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#	Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
120	CPRC	Network Adequacy	Quality Improvement	Esther Okajima/ Melinda Enos	Recredentialing Of Provider Network Is Monitored	Recredentialing of practitioners is completed timely	Recredentialing is processed every 36 months; Report of Admin term due to missed recredentialing cycle; Report of re-credentialing activity to CPRC	100% of all recredentialing files are processed within 36 months of last credentialing date	In Q1, 106 recredentialing cases were approved. 1 case exceeded the 36 month timeframe for re-credentialing.	The specific case that exceeded the 36 month timeframe was brought to CPRC in the 36 month. The practitioner had an 805, and the committee requested additional information in order to move forward with an approval. It took an additional two months to obtain the information and make a decision. The file was finally approved in February. Going forward, the credentialing team will take practitioner files with 805's to committee earlier in case additional information is required.	6/30/2018	
121	MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care for urgent appointments	1. Urgent care appointments without prior authorization within 48 hours of request 2.Urgent appointments with prior authorization with 96 hours of request	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment 90% minimum performance level	2018 Scores not yet available. For 2017 1) Primary Care Met 95.6% Speciality Care Not Met 81.1% 2) Not Met 75.4%	Contract with a new vendor to field Timely Access Survey. Issue Corrective Action Plans to HN with areas of non-compliance.	Q2 and Q3	
122	MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care specialty appointments	1. Appointment with specialist within 15 business days of request 2. Non-urgent, non-physician mental health appointment within 10 business days of request 3. First pre-natal visit within 10 days	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment 90% minimum performance level	2018 Scores not yet available. For 2017 1) Not Met 89.0% 2) MC Not Met 87.4% OC No respondents OCC Not Met 71.5% 3) Met 91.7%	Contract with a new vendor to field Timely Access Survey. Issue Corrective Action Plans to HN with areas of non-compliance.	Q2 and Q3	
123	AOC	Compliance	A&O	Solange Marvin/Karla Gutierrez	Delegation Oversight of HN Compliance (UM, CR, Claims)	Delegation Oversight of Health Networks to assess compliance of UM, CR, Claims	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations; Credentialing, Claims etc. **Report from AOC	98%	Medi-Cal Utilization Management (UM) Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2017) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. OneCare Utilization Management (UM) Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2017) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. OneCare Connect Utilization Management (UM) Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2017) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.	Next Step Corrective Action Plan issued and continued monitoring from performance Improvement.	ongoing	

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Member Trend Report: First Quarter 2018

Board of Directors' Quality Assurance Committee Meeting
September 12, 2018

Ana Aranda
Interim Director, Grievance and Appeals

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Overview

- Breakdown of complaints by category
- Trends in rate of complaints (appeals/grievances) per thousand members for all CalOptima programs for first quarter 2018
- Interventions based on trends, as appropriate

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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 the CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction.
- Quality of Care (QOC): Concerns regarding the care member received or feels should have been received.

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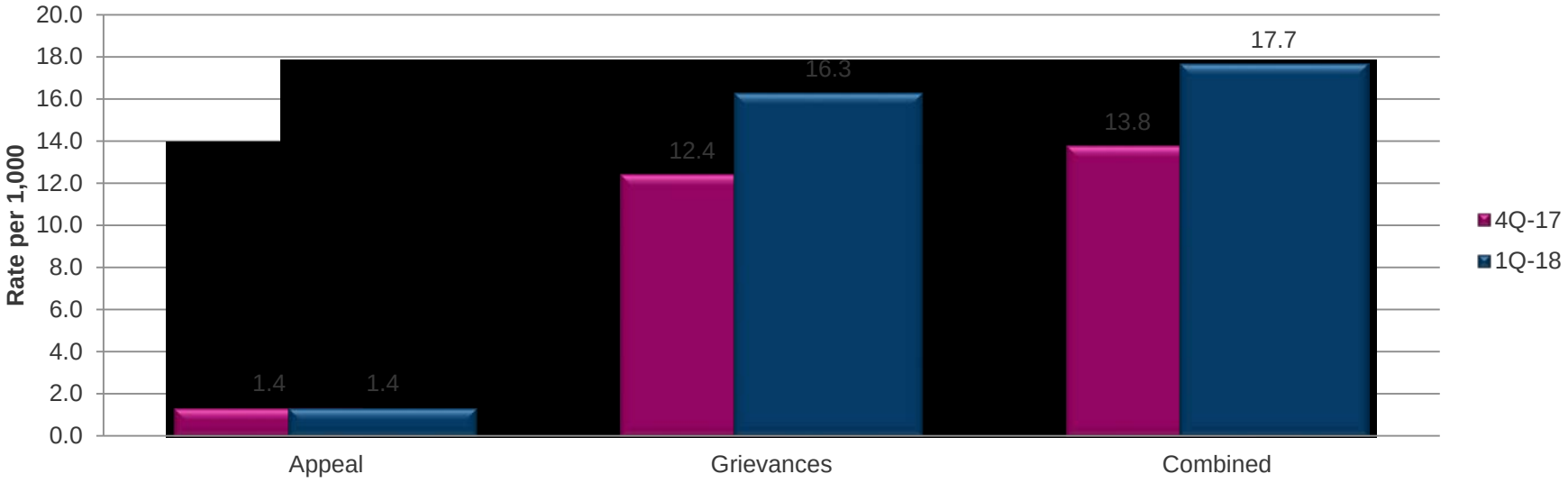
Medi-Cal Member Complaints



	Total Complaints	Appeals	Grievances	Membership
4Q-2017	2,670	263	2,407	772,146
1Q-2018	3,365	262	3,103	771,453

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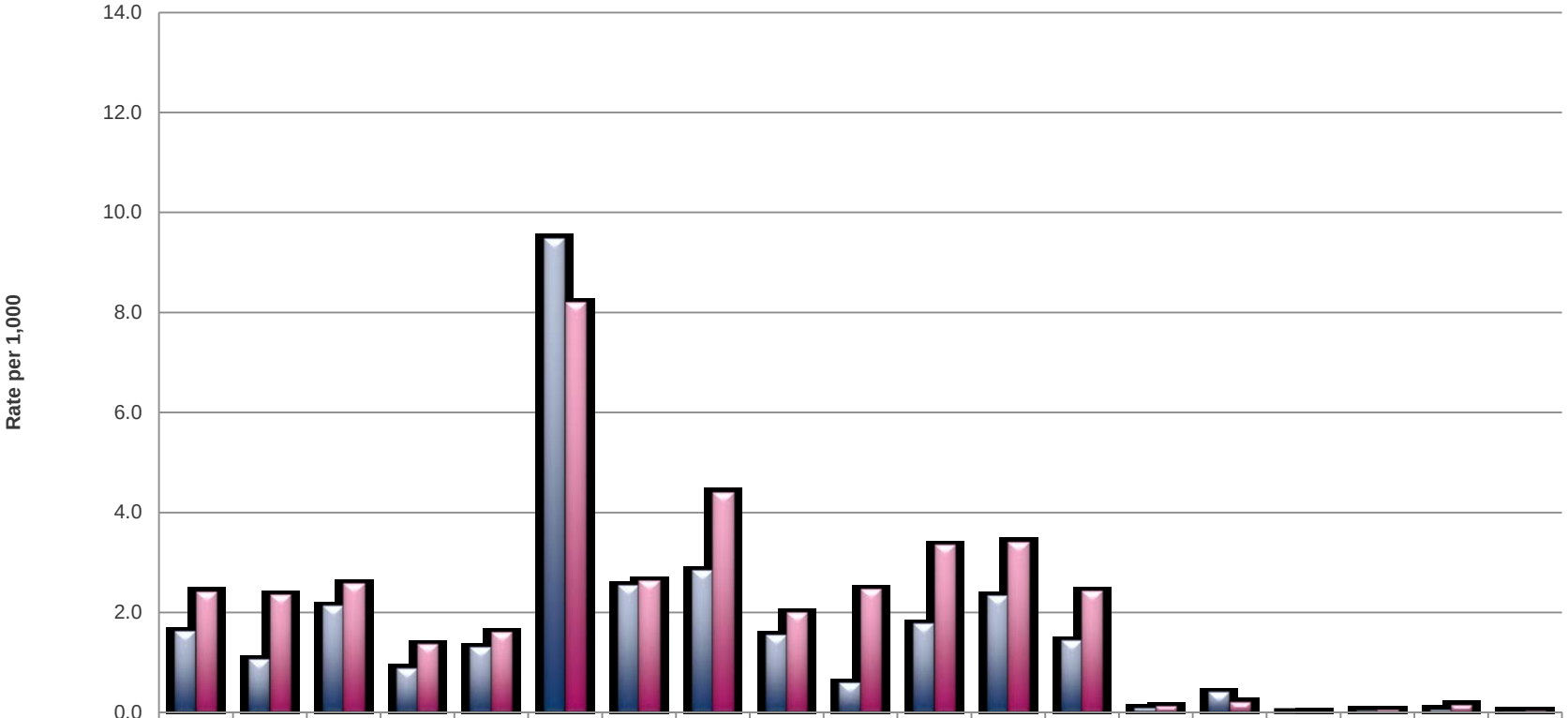
Medi-Cal Grievances
Quarterly Rate/1,000 Members



	AltaMed (45,825)	AMVI (23,379)	Arta (74,843)	CHA (150,042)	Family Choice (47,197)	Heritage (5,118)	Kaiser (45,811)	Monarch (83,567)	Noble (27,537)	OC Advantage (2,022)	Prospect (34,898)	Talbert (23,732)	UCMG (33,307)	CO Prog (771,453)	CO Pharm (725,642)	MLTSS (725,642)	American Logistics (771,453)	Behavioral Health (771,453)	VSP (725,642)
4Q-17 (2407)	1.63	1.06	2.13	0.88	1.31	9.49	2.55	2.84	1.55	0.59	1.77	2.34	1.43	0.08	0.40	0.00	0.04	0.06	0.03
1Q-18 (3103)	2.42	2.35	2.58	1.36	1.61	8.21	2.64	4.40	2.00	2.47	3.35	3.41	2.43	0.12	0.21	0.00	0.05	0.15	0.03

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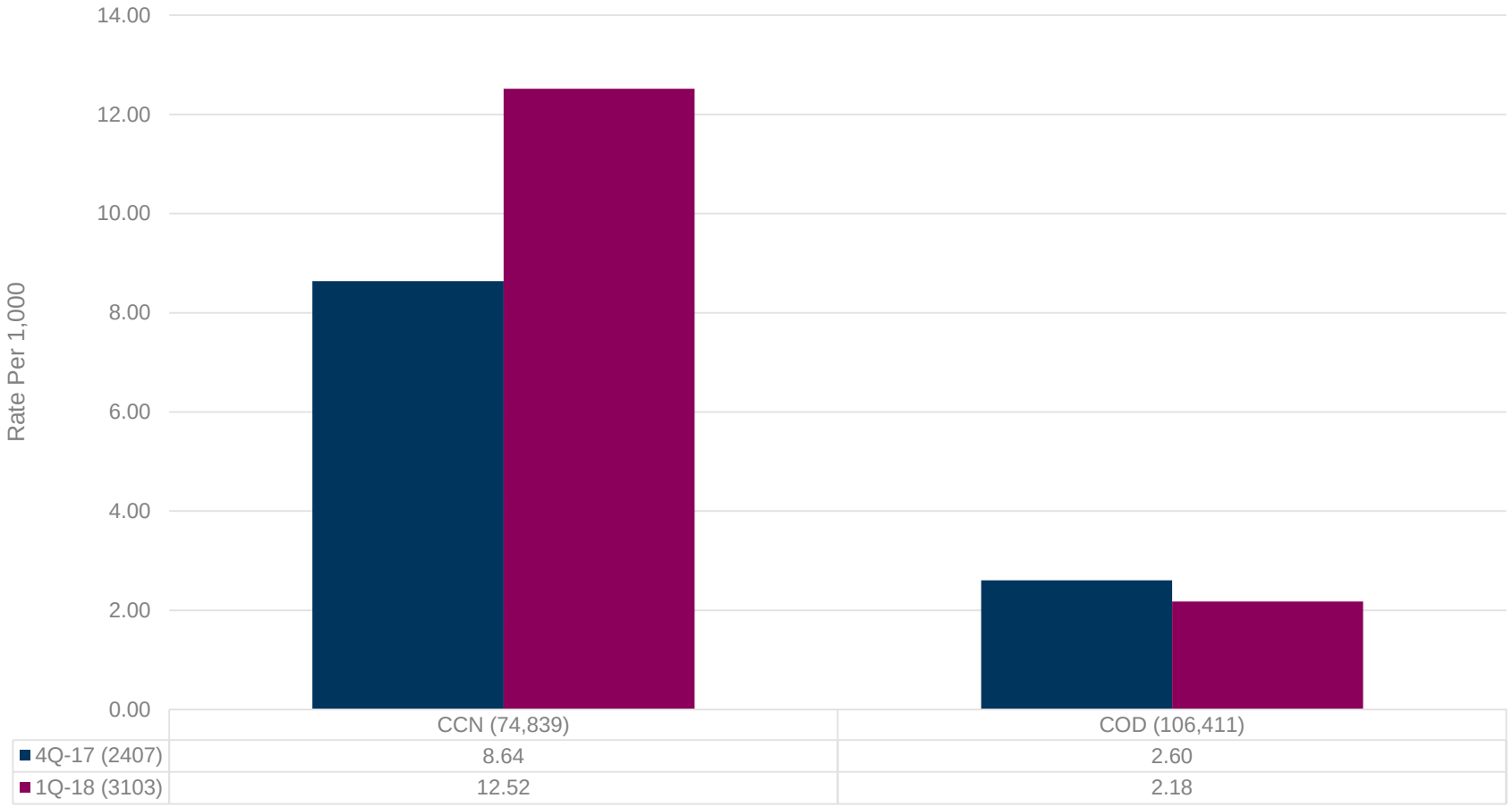
CCN/COD Medi-Cal Grievances Quarterly Rate/1,000 Members



	CCN (74,839)	COD (106,411)
4Q-17 (2407)	8.64	2.60
1Q-18 (3103)	12.52	2.18

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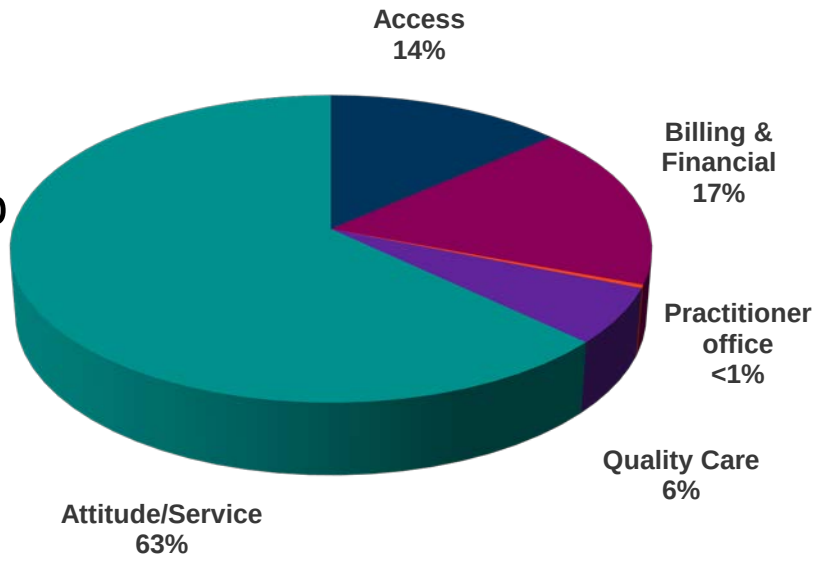
Medi-Cal Grievances by Category

- 3,103 grievances filed by 2,682 unique members in Q1 2018
  - 1,956 grievances (63%) were related to QOS
  - 183 grievances (6%) were related to QOC
  - The percentage by categories represents the historic trend.



- The Quality Improvement (QI) department continues to review for QOC issues.

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Medi-Cal Summary

- Quality of Service grievances accounted for the majority of the increase.
  - The increase is due to the ongoing improvements made to the categorization of grievances that were previously handled outside of the grievance process.
- Behavioral Health complaints increased from 43 in Q4 2017 to 116 in Q1 2018.
  - This is primarily due to the difference of CalOptima's categorization of grievances in comparison to Magellan Behavioral Health.

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Medi-Cal Summary (Cont.)

- CalOptima Community Network (CCN) complaints increased from 644 in Q4, 2017 to 937 in Q1, 2018, reflecting tightened grievance categorization in the following grievance types:
  - Appointment availability
  - Delays in service
  - Referrals to specialists
- Decrease in CalOptima Pharmacy complaints from 291 in Q4 2017 to 153 in Q1 2018.
  - ➢ This is due to the Pharmacy Department's clarification of the prior authorization rules and the regulatory requirements for the prior authorization process.

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Interventions

- Working with Customer Service in identifying grievances in order to track, trend, report and take action.
- Referring trends to the appropriate departments for correction, education or other necessary actions.
- A provider data initiative taskforce was created to implement improvements to the quality of the provider data.

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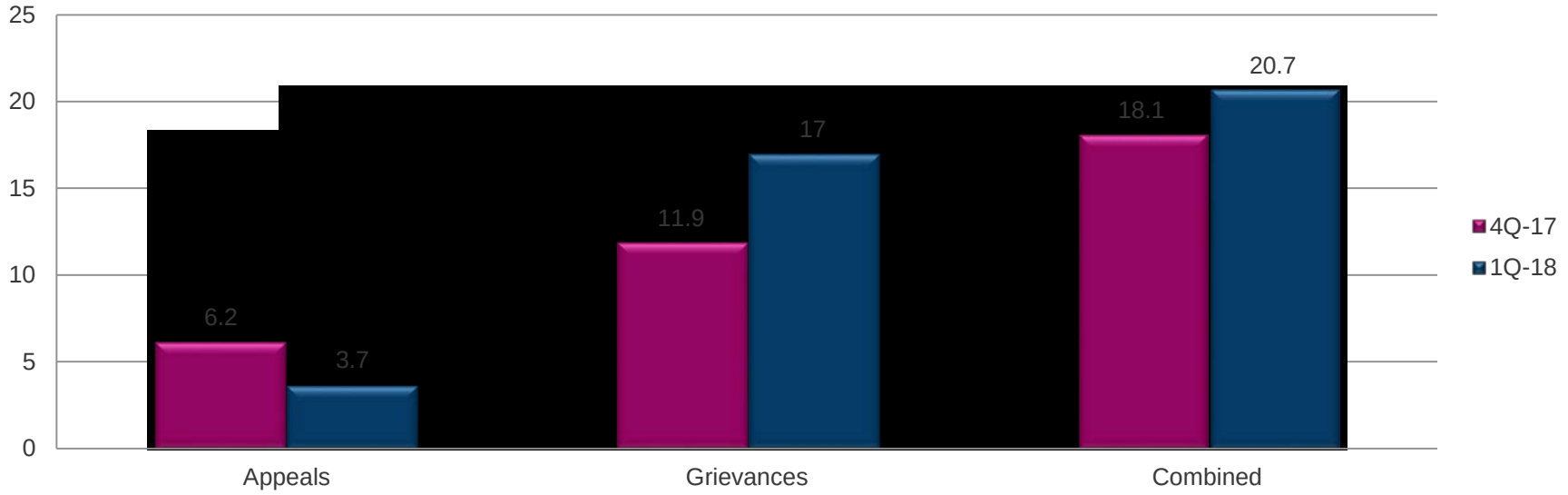
OneCare Connect Member Complaints



	Total Complaints	Appeals	Grievances	Membership
4Q-2017	277	95	182	15,281
1Q-2018	282	55	227	15,031

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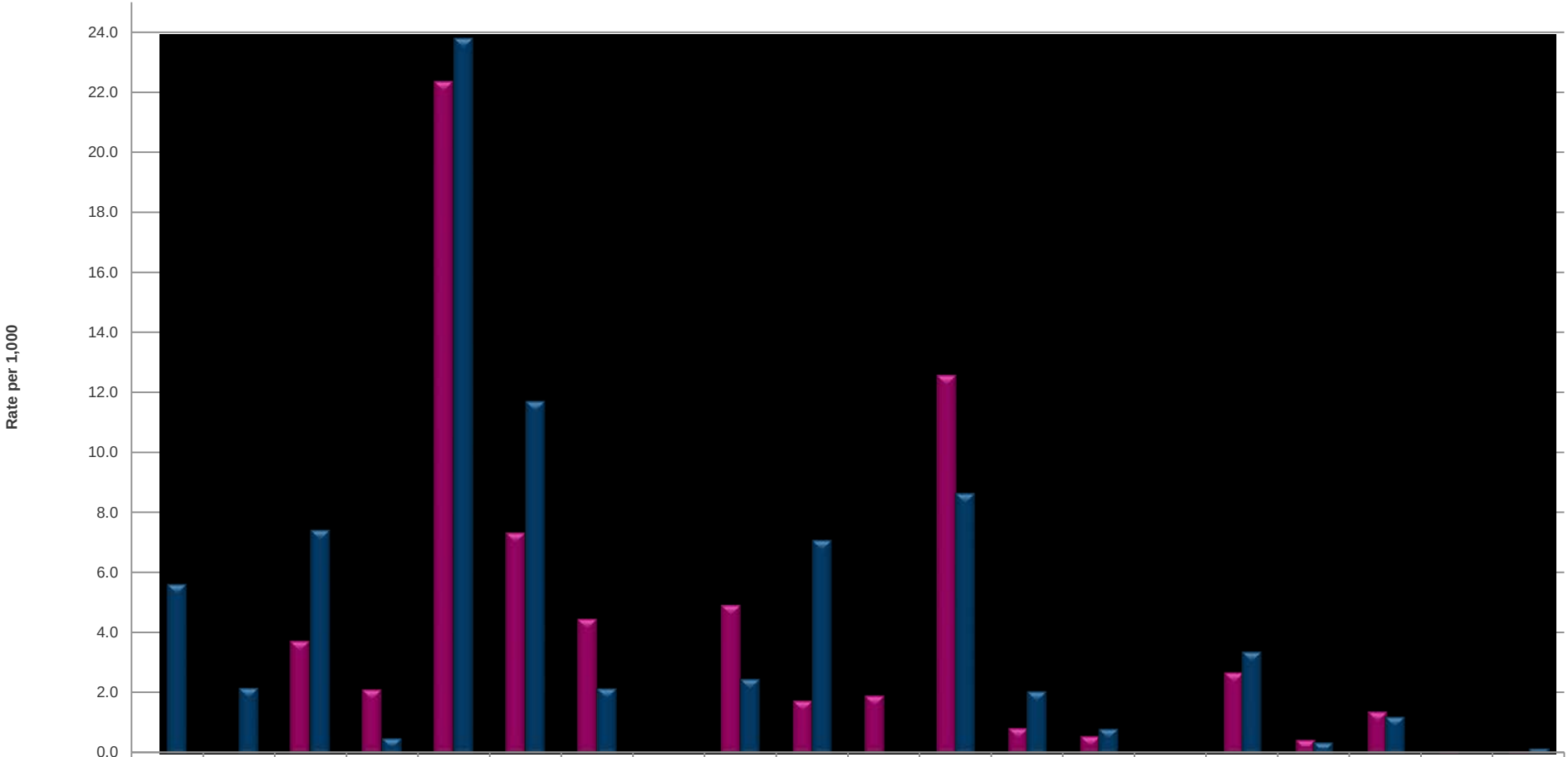
OneCare Connect Grievances Quarterly/1,000



	Alta Med Health (526)	AMVI Care (446)	Arta (534)	Family Choice (1,839)	Heritage (210)	Monarch (4,844)	Noble (449)	OC Adv (99)	Prospect (2,749)	Talbert (1,117)	UCMG (497)	CCN (1,722)	OCC Prog (15,031)	OCC Pharm (15,031)	MLTSS (15,031)	American Logistics (15,031)	Behavioral Health (15,031)	Liberty Dental (15,031)	Silver and Fit (15,031)	VSP (15,031)
4Q-17 (182)	0.0	0.0	3.7	2.1	22.4	7.4	4.5	0.0	4.9	1.8	1.9	12.6	0.9	0.6	0.0	2.7	0.5	1.4	0.1	0.1
1Q-18 (227)	5.7	2.2	7.5	0.5	23.8	11.8	2.2	0.0	2.5	7.2	0.0	8.7	2.1	0.9	0.0	3.5	0.4	1.3	0.0	0.2

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CalOptima A Public Agency Better. Together.

OneCare Connect Grievances by Category

- 227 grievances filed by 158 unique members in Q1 2018
  - 199 grievances (88%) were related to QOS
  - 21 grievances (9%) were related to QOC
  - The percentage by categories represents the historic trend.

- The QI department continues to review for QOC issues.

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OneCare Connect Summary

- There was a 25% increase of grievances from Q4, 2017 to Q1, 2018.
  - Increase attributed to same members filing multiple grievances
    - In Q4, 24 members filed 62 grievances
    - In Q1, 26 members filed 95 grievances
    - 53% increase of same member grievances from Q4 2017 to Q1 2018

Interventions

- The members filing multiple grievances have been assigned to key staff in the department to ensure appropriate coordination of services and care.
- The transportation vendor, American Logistics, continues to train their drivers and dispatchers in providing better service to members.
- Referred provider trends to Provider Relations for correction, education or other necessary actions.

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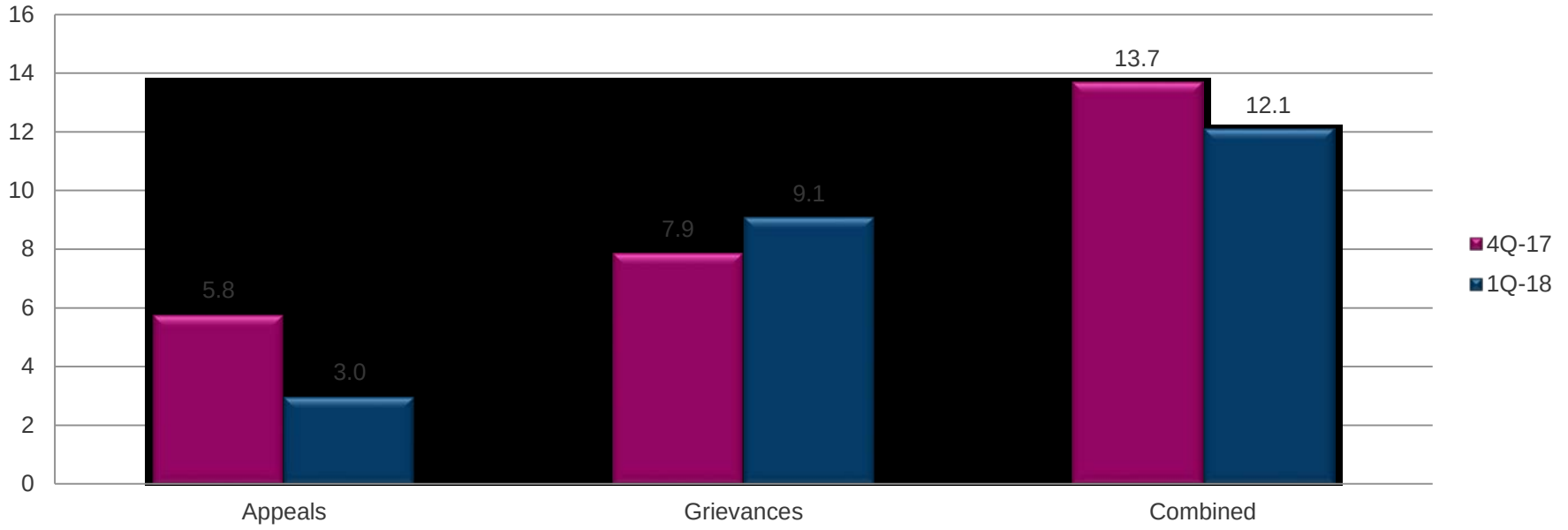
OneCare Member Complaints



	Total Complaints	Appeals	Grievances	Membership
4Q-2017	19	8	11	1,341
1Q-2018	16	4	12	1,325

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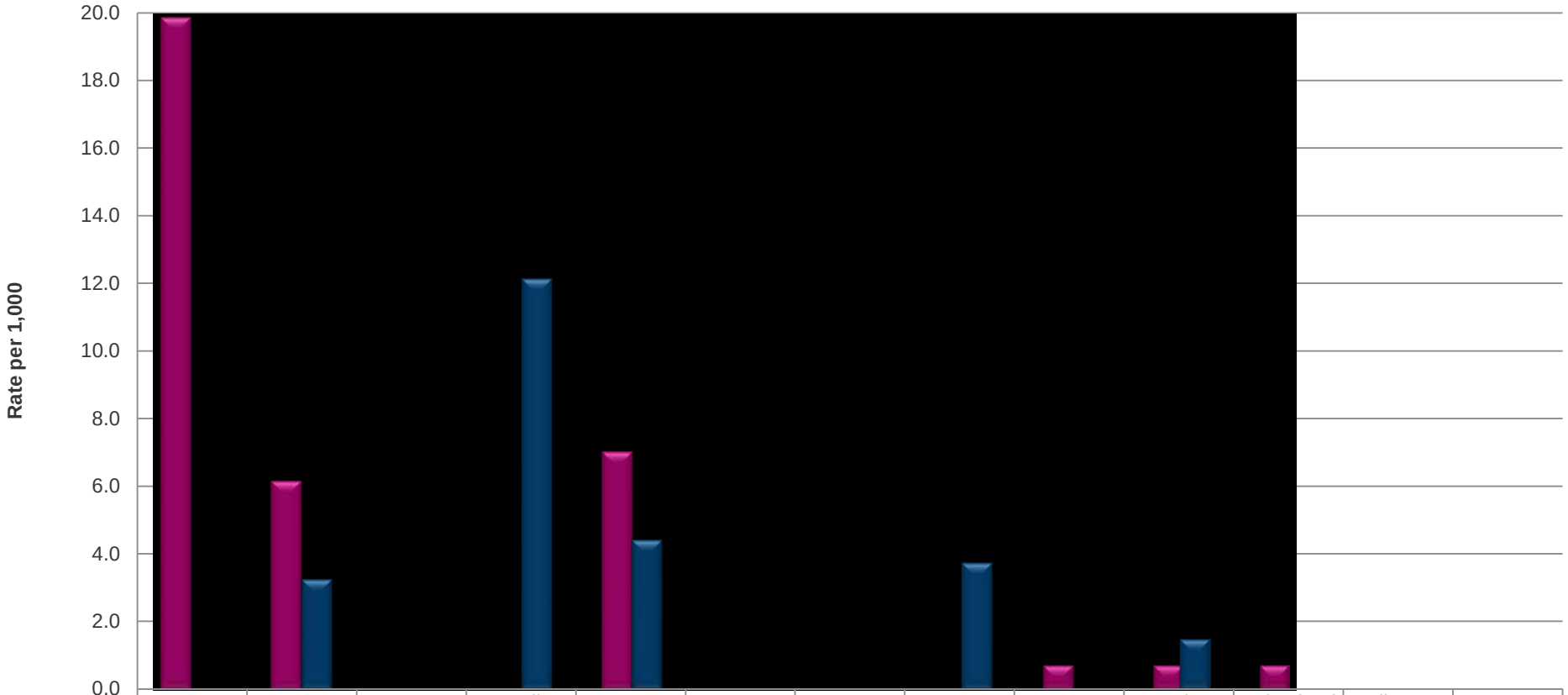
OneCare Grievances Quarterly/1,000



	Alta Med Health (51)	AMVI/ Prospect (304)	Arta Western (67)	Family Choice (82)	Monarch (674)	Talbert (107)	UCMG (26)	OC Operations (1,325)	OC Pharm (1,325)	American Logistics (1,325)	Behavioral Health (1,325)	Liberty Dental (1,325)	VSP (1,325)
4Q-17 (11)	19.87	6.17	0.00	0.00	7.04	0.00	0.00	0.00	0.72	0.72	0.72	0.00	0.00
1Q-18 (12)	0.0	3.3	0.0	12.1	4.5	0.0	0.0	3.8	0.0	1.5	0.0	0.0	0.0

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OneCare Summary

- The 12 grievances were service related with the majority categorized as:
  - Delay in service
    - Referrals
  - Primary Care Physician
    - Unprofessional
    - Lack of care
  - Transportation vendor
    - Refusal to schedule member's ride
    - Late arrival and drop off at wrong location
- OneCare grievance volume remains low.
- GARS continues to review for trends.

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CalOptima's Mission

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

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