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

WEDNESDAY, SEPTEMBER 16, 2020
3:00 P.M.

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

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
Mary Giammona, M.D., Chair
Jackie Brodsky
Trieu Tran, M.D.

INTERIM CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	Sharon Dwiers

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

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

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

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

1) **Listen to the live audio at +1 (562) 247-8321 Access Code: 168-435-807 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/1680299755008007779 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

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

MANAGEMENT REPORTS
1. Chief Medical Officer Update

CONSENT CALENDAR
2. Approve Minutes of the May 20, 2020 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
3. Consider Recommending Board of Directors' Approval to Redirect Intergovernmental Transfer (IGT) 9 Funds Allocated for Expanded Office Hours to Support Virtual Urgent Care Implementation During Coronavirus (COVID-19) Pandemic and Beyond

4. Consider Recommending Board of Directors' Approval of the Calendar Year 2021 Behavioral Health Applied Behavior Analysis Pay for Value Performance Program

INFORMATION ITEMS
5. HEDIS Update 2020

6. Intergovernmental Transfer Overview

7. Population Health and Behavioral Health Interventions During COVID19 Update

8. PACE Member Advisory Committee Update

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

CalOptima Board of Directors' Quality Assurance Committee

How to Join

1. Please register for CalOptima Board of Directors' Quality Assurance Committee Meeting on September 16, 2020 3:00 PM PDT at:

   https://attendee.gotowebinar.com/register/168029975500800779

2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.
   Note: This link should not be shared with others; it is unique to you.
   Before joining, be sure to check system requirements to avoid any connection issues.

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Chief Medical Officer Report

Board of Directors' Quality Assurance Committee

September 16, 2020

David Ramirez, M.D., Chief Medical Officer

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Welcome

- New Quality Assurance Committee (QAC) Members
- CalOptima Quality Leadership
  - Betsy Ha, RN, Executive Director of Quality and Population Health Management
  - Miles Masatsugu, M.D., Medical Director
  - Esther Okajima, Director of Quality Improvement
  - Kelly Rex-Kimmet, Director of Quality Analytics

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Welcome (Cont.)

- Committees reporting to the QAC
  - Quality Improvement Committee (QIC)
    - Whole-Child Model Clinical Advisory Committee (WCM CAC)
    - Utilization Management Committee (UMC)
    - Credentialing and Peer Review Committee (CPRC)
    - Member Experience Committee (MEMX)
    - Grievance & Appeals Resolution Services Committee (GARS)
    - Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PACE QIC)

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Oversight Responsibilities

- Quality Improvement (QI) Program
  - The purpose of the QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members.
- Quality Improvement Workplan
  - CalOptima strives to continuously improve the structure, processes and outcomes of our health care delivery system to serve members through actions outlined in the QI workplan.
- Annual Quality Reporting
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - National Committee for Quality Assurance (NCQA) Health Plan Rating
  - Centers for Medicare & Medicaid Services (CMS) Star Rating

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Quality Focus

- CalOptima develops programs that meet regulatory requirements and use evidence-based guidelines that incorporate data and best practices tailored to our populations.
- The scope of quality extends across the health care continuum, from primary, urgent, acute and subacute care to long-term care and end-of-life care.
- Our comprehensive, person-centered approach integrates physical and behavioral health, leveraging local care delivery systems and community partners for our members with vulnerabilities, disabilities and chronic illnesses.

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Accomplishments and Accolades

- Rated a top Medi-Cal plan by NCQA for the past six years (4.0 rating in 2019)
- Earned the award for Outstanding Performance by a Large Scale Medi-Cal Plan from the Department of Health Care Services (DHCS) for the past five years
- Accredited by NCQA at the Commendable level
- Earned 4.5 Stars from CMS for OneCare in 2019
- Received 100% of quality withhold incentives for OneCare Connect in 2019 and 2020
- Received “Supernova” and “Shooting Stars” distinctions from the National PACE Association for high rates of enrollment growth

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Challenges

- Member access to needed care: primary care, specialty care, behavioral health, skilled nursing and long-term acute care
- Medi-Cal provider reimbursement
- Oversight of hospital, provider and health network quality and performance
- Improving health outcomes for vulnerable populations, including CalOptima members experiencing homelessness
- Addressing social determinants of health, including adverse childhood experiences
- Relationships with hospitals

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Board Approved Quality Initiatives

- Whole-Child Model (WCM)
- Homeless Health Initiative (HHI)
- Health Homes Program (HHP)
- Adverse Childhood Experiences (ACEs) Aware
- Post-Acute Infection Prevention Quality Initiative (PIPQI) and PIPQI Expansion
- Nursing Home Infection Prevention Program
- Proposition 56 Provider Incentive Payments
- Expanded Office Hours Incentive Program
- PACE Without Walls
- Population Health and Behavioral Health interventions during COVID-19

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Proposed Initiatives (Require Board Approval)

- Medi-Cal Rx
- Medical Review Vendor with Enhanced Capabilities
- DHCS Behavioral Health Integration Grants
- Applied Behavioral Analysis (ABA) Pay for Value (P4V) Provider Incentives
- eConsult Vendor Selection
- Foster Care Model of Care
- Intergovernmental Transfer (IGT) 10 funds
- Flu vaccination campaign 2020–21
- 24/7 Acute Care and Behavioral Health Telehealth Vendor

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Our Mission

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

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 20, 2020

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on May 20, 2020 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:08 p.m. and led the Pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair (in-person); Dr. Nikan Khatibi (via teleconference)

Members Absent: Alexander Nguyen M.D.

Others Present: Richard Sanchez, Interim Chief Executive Officer; Gary Crockett, Chief Counsel, Betsy Ha, Executive Director, Quality and Population Health Management; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENTS
There were no public comments.

CONSENT CALENDAR

1. Approve the Minutes of the February 19, 2020 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

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

REPORTS

2. Consider Recommending Board of Directors' Approval of the 2019 CalOptima Utilization Management (UM) Program Evaluation and the 2020 CalOptima UM Program.
Tracy Hitzeman, R.N., Executive Director, Clinical Operations, reviewed the 2019 UM Program Evaluation, which measures plan performance against the 2019-approved goals. Notable accomplishments included the successful transition of CalOptima members eligible with the

California Children's Services Program (CCS) to the Whole Child Model (WCM) Program on July 1, 2019, and improved timeliness of CalOptima Direct (COD) expedited requests processing, exceeding goal of 98% and maintaining routine request processing with an average of 99.95% within turn-around-times. Areas of opportunity that staff identified in the 2019 UM Program Evaluation included improving visibility of operational performance of direct and delegated health networks and strengthening monitoring and auditing functions through inter-rater education and identification of best practices. Ms. Hitzeman noted that the results and outcomes from the 2019 Evaluation help inform areas of opportunity to include in the 2020 UM Program. Ms. Hitzeman presented an overview of the program description, including revisions and additions included in the proposed UM Program for 2020. The proposed changes are necessary to meet the requirements specified by the Centers of Medicare & Medicaid Services, California Department of Health Care Services, and the National Committee on Quality Assurance (NCQA) accreditation standards.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors approval of the 2019 CalOptima Utilization Management Program Evaluation and the 2020 CalOptima UM Program. (Motion carried 2-0-0; Director Nguyen absent)***

INFORMATION ITEMS

3. COVID-19 Impact on Quality and Population Health Management

Kelly Rex-Kimmet, Director, Quality Analytics, provided an update on the impact that COVID-19 has had on quality reporting requirements. Due to the impact of COVID-19 on provider offices, the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) have issued guidance related to quality reporting requirement for measurement year (MY) 2019. Ms. Rex-Kimmet noted that with the requirement for Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results to be reported to CMS for MY 2019 performance suspended, this will impact the OneCare program star rating. Since no new data will be available, we will be rated based on CalOptima MY 2018 performance.

Esther Okajima, Director, Quality Improvement, provided a brief overview on COVID-19 and its Impact on Member Experience and Provider Experience. Ms. Okajima reviewed some of the main issues that CalOptima members are reporting which include delays in getting care, lack of testing availability, appointments getting rescheduled or cancelled, and denied testing or providers not making referrals to test members. Members are also reporting delays in obtaining medications and durable medical equipment (DME). For CalOptima providers, their reported experiences include: the need to change hours, consolidating services and sites, canceling elective surgeries and procedures, changing to phone consultations/telehealth, lack of clarity on testing sites and testing strategy. CalOptima also received several inquiries regarding Community-Based Adult Services (CBAS) hours of operation. With regard to testing, Miles Masatsugu, M.D., Medical Director, added that CalOptima has been working closely with the County to ensure that members are able to get tests if they are symptomatic. Dr. Masatsugu also noted that because the guidance is continuing to be updated frequently,CalOptima follows the guidelines communicated by the County Health Officer and Orange County Health Care Agency for COVID-19 testing criteria.

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Related to CBAS, Chair Yost mentioned that he had received a letter about possible cuts to the program. Interim CEO, Richard Sanchez responded that this is part of the Governor's May Revise of the state budget and CalOptima has received requests from CBAS providers regarding a letter of support. Chair Yost responded that the QAC Committee would be supportive of the CalOptima Board sending a letter of support for the CBAS program.

Pshyra Jones, Director, Population Health Management, reported on member outreach efforts to emerging risk populations during the pandemic. Ms. Jones noted that CalOptima is providing COVID-19 outreach and prevention awareness via weekly mailings and has modified guidance for expectant mothers and best practices during delivery. In addition, CalOptima is providing general education and prevention awareness via an interactive voice response campaign. CalOptima has created a COVID-19 Community Awareness campaign and there are also educational videos on the CalOptima website.

Edwin Poon, Ph.D., Director, Behavioral Health Integration, provided an overview of the DHCS All Plan Letter (APL) 20-008 which provides guidance on mitigating health impact of secondary stress due to the COVID-19 pandemic. Dr. Poon noted that CalOptima continues to work with providers on the Adverse Childhood Experiences (ACEs) screening and the importance of mental health, including community-focused activities which includes collaboration with county behavioral health services and Be Well OC on sharing mental health resources, and educating community-based organizations on how to support members with mental health concerns due to the COVID-19 pandemic.

4. CalOptima Members Experiencing Homelessness Update

Marie J Jeannis, RN, Interim Director, Enterprise Analytics, provided an update on the transition of care for members experiencing homelessness. CalOptima's Homeless Population Clinical Report Card is reported quarterly and monitors key performance measures for this vulnerable population. The Report Card includes information on enrollment, utilization metrics and number of Clinical Field Team visits and Mobile Clinic visits. Ms. Jeannis noted that utilization of telehealth services has increased measurably due to the COVID-19 pandemic and social distancing. The Coroners' case reporting frequency has been increased to weekly (from monthly) to facilitate identification of trends. Of the reported deaths, roughly 50 to 65 percent are typically CalOptima members. Most of the deaths are not currently attributed to COVID-19, but many results regarding cause of death are pending. Ms. Jeannis also noted that Orange County has substantially increased the number of available shelter beds and locations.

Richard Sanchez, Interim Chief Executive Officer, noted that because of the COVID-19 pandemic, the linking of services has increased and the response has been the County's responsibility as part of the statewide Project Roomkey initiative, which is intended to protect the homeless by getting them off of the street. Mr. Sanchez also noted that there is talk about the County buying these hotels and turning them into permanent housing for the homeless population.

The following Information Items were accepted as presented:

5. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Committee Quarterly Report
   b. Member Trend Report

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COMMITTEE MEMBER COMMENTS

Chair Yost read comments from Director Nguyen, who was unable to attend today's meeting.

In the comments, Director Nguyen thanked staff and his fellow committee members for their work and for their focus on ensuring that CalOptima members have access to quality health care services.

Dr. Yost commented that this was also his last QAC meeting and noted he has always gravitated toward the QAC because of its focus on members and the health care services they receive. He also thanked staff for their work on behalf of CalOptima's members.

ADJOURNMENT

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

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 16, 2020

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 16, 2020
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

3. Consider Recommending Board of Directors' Approval to Redirect Intergovernmental Transfer (IGT) 9 Funds Allocated for Expanded Office Hours to Support Virtual Urgent Care Implementation During Coronavirus (COVID-19) Pandemic and Beyond

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8400

Recommended Action

Recommend that the Board of Directors' approve the redirection of up to $2.0 million of IGT 9 funds originally allocated for the Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) Pilot towards contracting with a 24/7 virtual urgent care vendor for services that will include implementation and rapid deployment support for CalOptima Community Network (CCN) members during and after the COVID-19 pandemic

Background

On April 2, 2020, the Board of Directors (the Board) approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas (refer to Attachment 1). Among these focus areas, the Board approved allocating $2.0 million for Expanded Office Hours to improve member access and engagement.

On May 7, 2020, CalOptima staff presented the Virtual Care Strategy and Roadmap (refer to Attachment 2) to provide additional access to quality care for our members and providers during and after the pandemic. One of the strategies introduced to the Board was to contract with a vendor offering virtual urgent care visits, including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions. However, this strategy was postponed due to lack of available funding and deferred until CalOptima staff is able to identify appropriate funding.

As the COVID-19 pandemic continues to spread and disrupt the lives of many CalOptima members, CalOptima staff re-evaluated the structure of the Expanded Office Hours program and concluded that CalOptima is faced with new access challenges due to the COVID-19 pandemic that should be addressed. The Expanded Office Hours program was originally designed to provide additional office hours access to members in highly demanded and impacted areas. However, with the ongoing pandemic, members are less willing to come into the office for routine and preventive care services due to fear of COVID-19 and many provider offices are experiencing decreased office visits, and hence are less willing to expand their available office hours.

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Discussion

The Expanded Office Hours pilot was proposed as a two-year program to incentivize primary care providers and/or clinics to expand after-hour primary care services for CalOptima members in highly demanded and highly impacted areas. Unfortunately, this program was developed before the COVID-19 pandemic, and CalOptima staff now recommends shifting our efforts to support the urgent needs of our members through the use of virtual care.

CalOptima staff proposes redirecting the $2 million IGT-9 funds originally allocated for the Expanded Office Hours pilot to release a Request for Proposal (RFP) and selecting a vendor that meets our CCN members' medical needs and CalOptima's business requirements during the COVID-19 pandemic. Staff recommends starting this program with CCN members first and will consider extending it to other networks in the future. Staff will return to the Board to seek authority for approval to contract with the recommended vendor selected through the RFP process for services that will include a virtual care platform and virtual provider network, along with virtual care expertise to ensure a successful implementation of the 24/7 virtual urgent care initiative, including member and provider engagement and adoption.

With this proposed virtual care strategy, CalOptima staff believe that virtual urgent care after hours can improve member access to needed care on demand, decrease wait times, and reduce avoidable emergency department visits.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for as part of the Medi-Cal capitation revenue CalOptima receives from the Department of Health Care Services (DHCS) in exchange for making covered, medically-necessary care available to assigned Medi-Cal beneficiaries. Any expenditures of IGT-9 funds not meeting these requirements are categorized by the DHCS as part of CalOptima's administrative expenses. The recommendation to redirect Board-allocated IGT 9 funds to virtual urgent care services is consistent with the purpose of the IGT 9 funds to cover medically necessary Medi-Cal services or qualifying quality initiatives.

Fiscal Impact

The recommended action to redirect $2.0 million in IGT 9 funds from the Expanded Office Hours Pilot to support 24/7 virtual urgent care services for CCN members during the pandemic has no net impact to CalOptima's fiscal position. IGT 9 revenue from DHCS in Fiscal Year 2019-20 was sufficient to cover the allocated expenditures and initiatives. This expenditure of IGT funds is for a restricted, one-time purpose for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

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Rationale for Recommendation

The recommended action is consistent with the original aim for IGT 9 to improve Member Access and Engagement and will enable CalOptima to provide increased access to quality care for CCN members during and after the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated April 2, 2020, Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds
2. Board Action dated May 7, 2020, Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

/s/ Richard Sanchez *09/09/2020*

Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Approval of Allocation of Intergovernmental Transfer (IGT) 9 Funds

Contact

David Ramirez, Chief Medical Officer (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400
Candice Gomez, Executive Director Program Implementation (714) 246-8400

Recommended Actions

1. Approve the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of:
    a. Additional initiative(s) related to member access and engagement; and
    b. New and/or modified policies and procedures, and contracts/contract amendments, as applicable.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2020-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS.

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between the California Department of Health Care Services (DHCS) and CalOptima for the current fiscal year. Funds must be used for CalOptima covered Medi-Cal services per DHCS requirements. Upon Board approval, funds may be allocated and used over multiple years. IGT 8 funds have been allocated to the Homeless Health Initiative. In July 2018, CalOptima received notice from DHCS regarding the fiscal year 2018-19 Voluntary Rate Range IGT 9. While supporting documents were submitted to DHCS in August 2018, IGT 9 funds have not yet been received or allocated. Submission of documentation to participate in IGT 9 was ratified at the September 9, 2018

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Board of Directors meeting. CalOptima is expected to receive funding from DHCS in calendar year 2020. CalOptima's estimated share is expected to be approximately $45 million. Following consideration by the Quality Assurance Committee and Finance and Audit Committee at their respective February 2020 meetings and the committees' recommendations for approval by the full Board, this item was presented for approval at the March CalOptima Board meeting. At that meeting, staff was directed to conduct further study and provide additional details related to the Whole Child Model pilot program (WCM) and the program's financial performance. Details on the WCM program are provided in a separate WCM-specific Information Item.

Discussion

While IGT 1-7 funds were available to provide enhanced services to existing CalOptima Medi-Cal beneficiaries, beginning with IGT 8, the requirement is that IGT funds are to be used for Medi-Cal program covered services and operations. IGT 8 (and subsequent IGT) funds are subject to all applicable requirements set forth in the CalOptima Medi-Cal contract with DHCS and are considered part of the capitation payments CalOptima receives from DHCS and are accounted for as either medical or administrative expenses, and factor into CalOptima's Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR). As indicated, per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

While IGT 9 funds have not yet been received, CalOptima staff has begun planning to support use of the funds. CalOptima staff has considered the DHCS requirements for use of IGT 9 funds and Board approved strategic priorities and objectives in identifying the following focus areas:

- Member access and engagement
- Quality performance
- Data exchange and support
- Other priority areas

CalOptima staff has and will continue to share information about the proposed focus areas with various stakeholders.

CalOptima staff anticipates receiving approximately $45 million in IGT 9 funding. Staff has identified initiatives within four focus areas targeting $40.5 million of the anticipated $45 million. Staff proposes approval of the five initiatives and allocation of funds in the focus areas as noted below and as further described in the attached IGT Funding Proposals:

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million

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4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. Whole Child Model (WCM) Program	Other priority areas	One–year	Up to $31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	$4.5 million

CalOptima staff will return to the Board with recommendations related the remaining estimated $4.5 million towards member access and engagement, as well as regarding new and/or modified policies and procedures, and contracts, if necessary.

Fiscal Impact

The recommended action has no net fiscal impact to CalOptima's operating budget over the proposed project terms. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures and initiatives recommended in this COBAR.

Rationale for Recommendation

CalOptima staff is recommending the use of IGT funds in a manner consistent with state parameters for IGT funds, identified focus areas.

Concurrence

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

Attachments

1. Power Point Presentation: Intergovernmental Transfer (IGT) 9 Update
2. CalOptima Board Action dated September 6, 2018, Consider and Authorize Activities to Secure Medi-Cal Funds through IGT 9
3. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Incentive Payments
4. IGT Funding Proposals

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

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Intergovernmental Transfer (IGT) 9 Update

Board of Directors Meeting
April 2, 2020

David Ramirez, M.D., Chief Medical Officer
Nancy Huang, Chief Financial Officer
Candice Gomez, Executive Director, Program Implementation

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IGT Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGT 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
    - Funds are outside of operating income and expenses
  - IGT 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
    - Funds are part of operating income and expenses

IGT Funding Process

High-Level Overview
1. CalOptima receives DHCS notice announcing IGT opportunity
2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et al.)
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contributions and an additional 20% fee to DHCS
5. CMS provides matching funds to DHCS
6. DHCS sends total amount to CalOptima
7. From the total amount, CalOptima returns each funding partner's original contribution
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and where applicable, retained amount for MCO tax (IGT 1–6 only)
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees

CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic)/ March 2016 (MCE)
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9*	TBD	TBD (Spring 2020)
IGT 10*	TBD	TBD
Total Received	**$121.31 million**	

** Pending DHCS guidance*

IGT 9 Status

- CalOptima's estimated share is approximately $45 million
  - Expect receipt of funding in calendar year 2020
  - Funds used for Medi-Cal programs, services and operations
  - Funds are part of operating income and expenses
    - Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
    - Managed through the fiscal year budget

- Stakeholder vetting on the following focus areas
  - Member access and engagement
  - Quality performance
  - Data exchange and support
  - Other priority areas

Proposed Allocation and Initiatives

- Staff has identified initiatives targeted $40.5 million of the anticipated $45 million

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million
4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. W hole Child Model Program	Other priority areas	One–year	Up to $31.1 million
6. Future Request Prior to End of Fiscal Year	Member access and engagement	To be determined	$4.5 million

1. Member Access and Engagement: Expanded Office Hours

- Description
  - Offer additional incentives to providers and/or clinics
    - Expand office hours in the evening and weekends
    - Expand primary care services to ensure timely access
- Guidelines
  - Primary care providers in community clinics serving members in high-demand/impacted areas are eligible
  - Per-visit access incentive awarded to providers and/or clinics for members seen during expanded hours
- Key Components
  - Two-year initiative
  - Budget request of $2.0 million ($500,000 in FY 2019–20)

2. Quality Performance: Post-Acute Infection Prevention Initiative (PIPQI)

- Description
  - Expand CalOptima's PIPQI to suppress multidrug-resistant organisms in contracted skilled nursing facilities (SNFs) and decrease inpatient admissions for infection
- Guidelines
  - Phase 1: Training for 41 CalOptima-contracted SNFs not currently participating in initiative
  - Phase 2: Compliance, quality measures and performance incentives for all participating facilities
  - Two FTE to support adoption, training and monitoring
- Key Components
  - Three-year initiative
  - Budget request of $3.4 million ($1 million in FY 2019–20)

3. Data Exchange: Hospital Data Exchange Incentive

- Description
  - Support data sharing among contracted and participating hospitals via use of CalOptima selected vendors
    - Other organizations within the delivery system may also be added
  - Enhance monitoring of hospital activities for CalOptima's members, aiming to improve care management and lower costs
- Guidelines
  - Participating organizations will:
    - Work with CalOptima and vendor to facilitate sharing of ADT (Admit, Discharge, Transfer) and Electronic Health Record data
    - Be eligible for an incentive once each file exchange is in place
- Key Components
  - One-year initiative
  - Budget request of $2.0 million (CY 2020)

4. Other Priorities: IGT Program Administration

- Definition
  - Administrative support for prior, current and future IGTs
    - Continue support for two existing staff positions to manage IGT transaction process, project and expenditure oversight
    - Fund Grant Management System license, public activities and other administrative costs
- Guidelines
  - Will be consistent with CalOptima policies and procedures
  - Will provide oversight of the entire IGT process and ensure funding investments are aligned with CalOptima strategic priorities and member needs
- Key Components
  - Five years of support
  - Budget request of $2.0 million

5. Other Priorities: Whole-Child Model (WCM) Program

- Definition
  - CalOptima launched WCM on July 1, 2019
  - Based on the initial analysis, CalOptima is projecting an overall loss of up to $31.1 million in FY 2019–20
- Challenges
  - Insufficient revenue from DHCS to cover WCM services
  - Complex operations and financial reconciliation
- Key Components
  - One year
  - Budget request of up to $31.1 million to fund the deficit from WCM program in FY 2019–20

Next Steps

- Return to the Board as needed regarding
  - New or modified policy and procedures
  - Contracts
  - Additional initiatives

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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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Ratify and authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), IGT funds must now be used in the current rate year for CalOptima covered

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services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date. .

Fiscal Impact
The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

Rationale for Recommendation
Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

Concurrence
Gary Crockett, Chief Counsel

Attachment
Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — *8/29/2018*
Authorized Signature — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

July 31, 2018

Greg Hamblin
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Mr. Hamblin:

The 2018-19 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR SFY 2018-19:

MCPs should refer to the estimated SFY 2018-19 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the 2018-19 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.

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2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2018-19. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:

  1. The governmental funding entity's name and Federal Tax Identification Number,
  2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
  3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).

- The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.

- The proposals and letters of interest are due to DHCS ***by 5pm on Friday, August 31, 2018***. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their

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uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the 2018-19 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

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ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of [Insert Participating Funding Entity Name], a governmental entity, federal I.D. Number [Insert Federal Tax I.D. Number], in working with [Managed Care Plan's Name] (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2018, to June 30, 2019. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

[Insert Participating Funding Entity Name] is willing to contribute up to $_____ for the SFY 2018-19 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

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Attachment B

SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

   If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. For any capitation payments to be funded by the IGT, please provide the following:

   (i) The name of the entity transferring funds:

   (ii) The operational nature of the entity (state, county, city, other):

   (iii) The source of the funds:
   (Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

   (iv) Does the transferring entity have general taxing authority? *(Yes / No)*

   (v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction? *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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Orange County Organized Health System dba Cal Optima - Orange (HCP 506)
IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	$ 138,114,451	$ 68,412,249	$ 7,133,302	$ 62,568,900
Federal Match	$ 98,985,353	$ 34,206,125	$ 6,277,306	$ 58,501,922
Governmental Funding Entity's Portion	$ 39,129,098	$ 34,206,124	$ 855,996	$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 12,571,887
Child - MCHIP	1,273,587	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 6,469,822
Adult - non MCHIP	1,082,406	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 18,898,809
Adult - MCHIP	38,000	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 663,480
SPD	466,754	$ 755.18	$ 798.48	$ 43.30	$ -	$ 43.30	$ 20,210,448
SPD/Full-Dual	22,704	$ 219.25	$ 229.52	$ 10.27	$ -	$ 10.27	$ 233,170
BCCTP	7,156	$ 1,225.69	$ 1,296.82	$ 71.13	$ -	$ 71.13	$ 509,006
LTC	14,686	$ 10,472.34	$ 10,858.28	$ 385.94	$ -	$ 385.94	$ 5,667,915
LTC/Full-Dual	0	$ 6,036.73	$ 6,235.58	$ 198.85	$ -	$ 198.85	$ -
OBRA	0	$ -	$ -	$ -	$ -	$ -	$ -
Whole Child Model	74,642	$ 1,824.65	$ 1,962.92	$ 138.27	$ -	$ 138.27	$ 10,321,014
Optional Expansion	2,853,119	$ 442.21	$ 471.45	$ 29.24	$ 7.31	$ 21.93	$ 62,568,900
	8,307,835	$ 309.49	$ 328.62	$ 19.14	$ 2.51	$ 16.62	$ 138,114,451

[1]The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.
[2]Other Departmental Usages decreases available rate range funding.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "…decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "…the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

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The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

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Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed $2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

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Post-Acute Infection Prevention Quality Initiative

Regular Meeting of the Board of Directors

June 6, 2019

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

Care Management, Long-Term Services and Supports and Senior Programs

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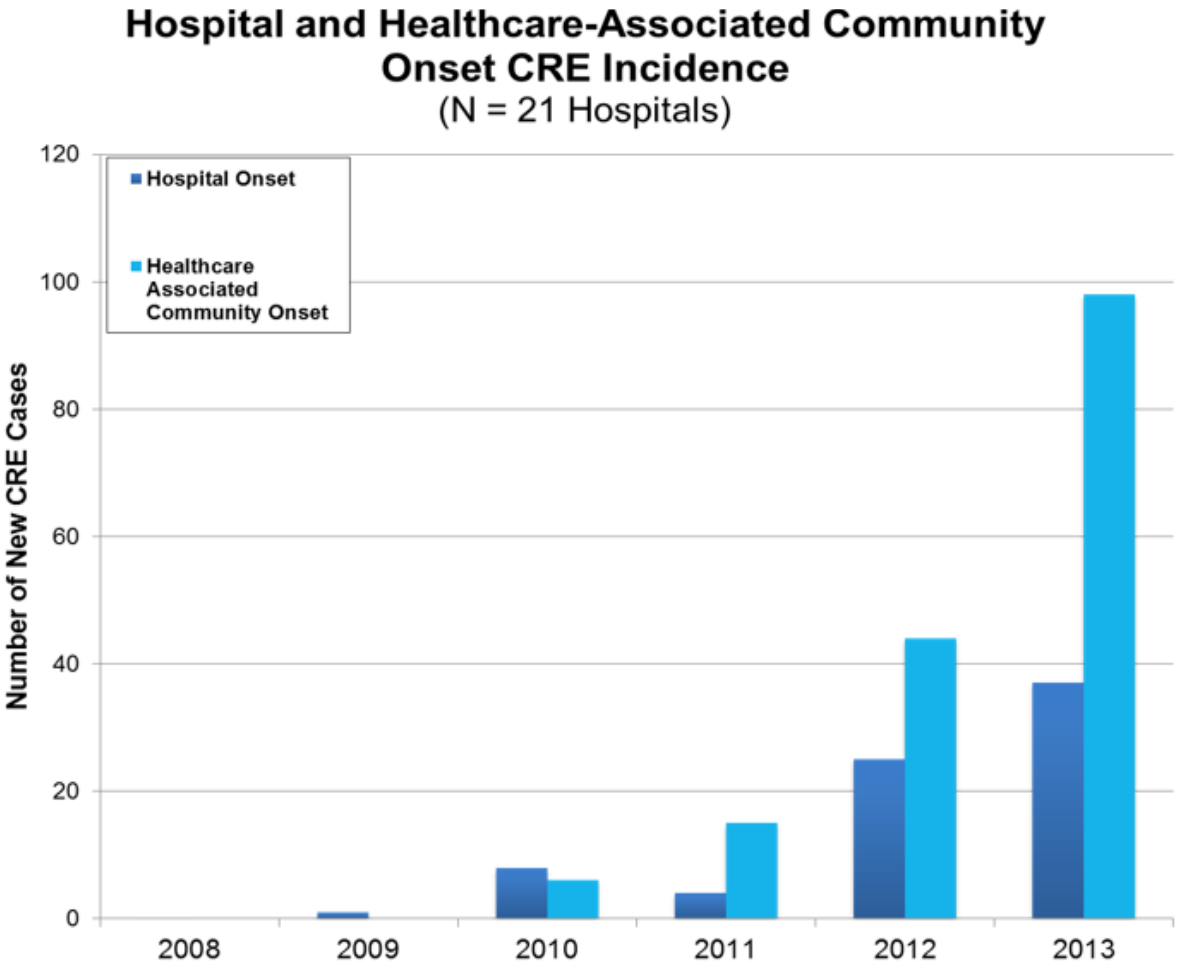
Background

- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 ➔ overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15%of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

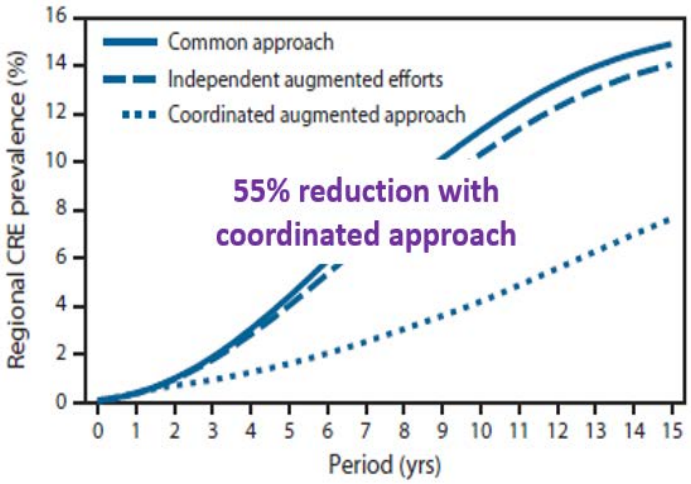
Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 64
August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD[1]; Damon Toth, PhD[2]; Bruce Y. Lee, MD[3]; Windy Tanner, PhD[2]; Sarah M. Bartsch, MPH[3]; Karim Khader, PhD[2]; Kim Wong, PhD[4]; Kevin Brown, PhD[2]; James A. McKinnell, MD[5]; William Ray[2]; Loren G. Miller, MD[6]; Michael Rubin, MD, PhD[2]; Diane S. Kim[7]; Fred Adler, PhD[8]; Chenghua Cao, MPH[7]; Lacey Avery, MA[1]; Nathan T.B. Stone, PhD[9]; Alexander Kallen, MD[1]; Matthew Samore, MD[2]; Susan S. Huang, MD[7]; Scott Fridkin, MD[1]; John A. Jernigan, MD[1]

FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*

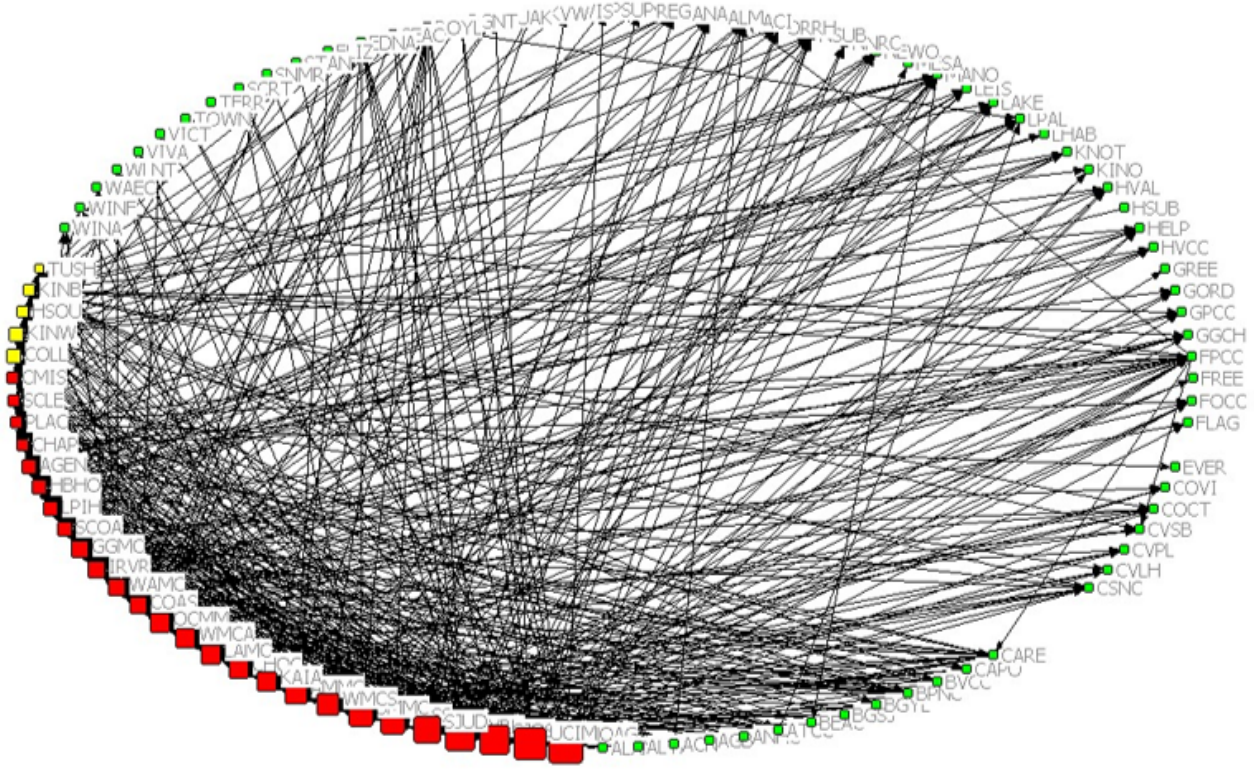


* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html.

Extent of the Problem

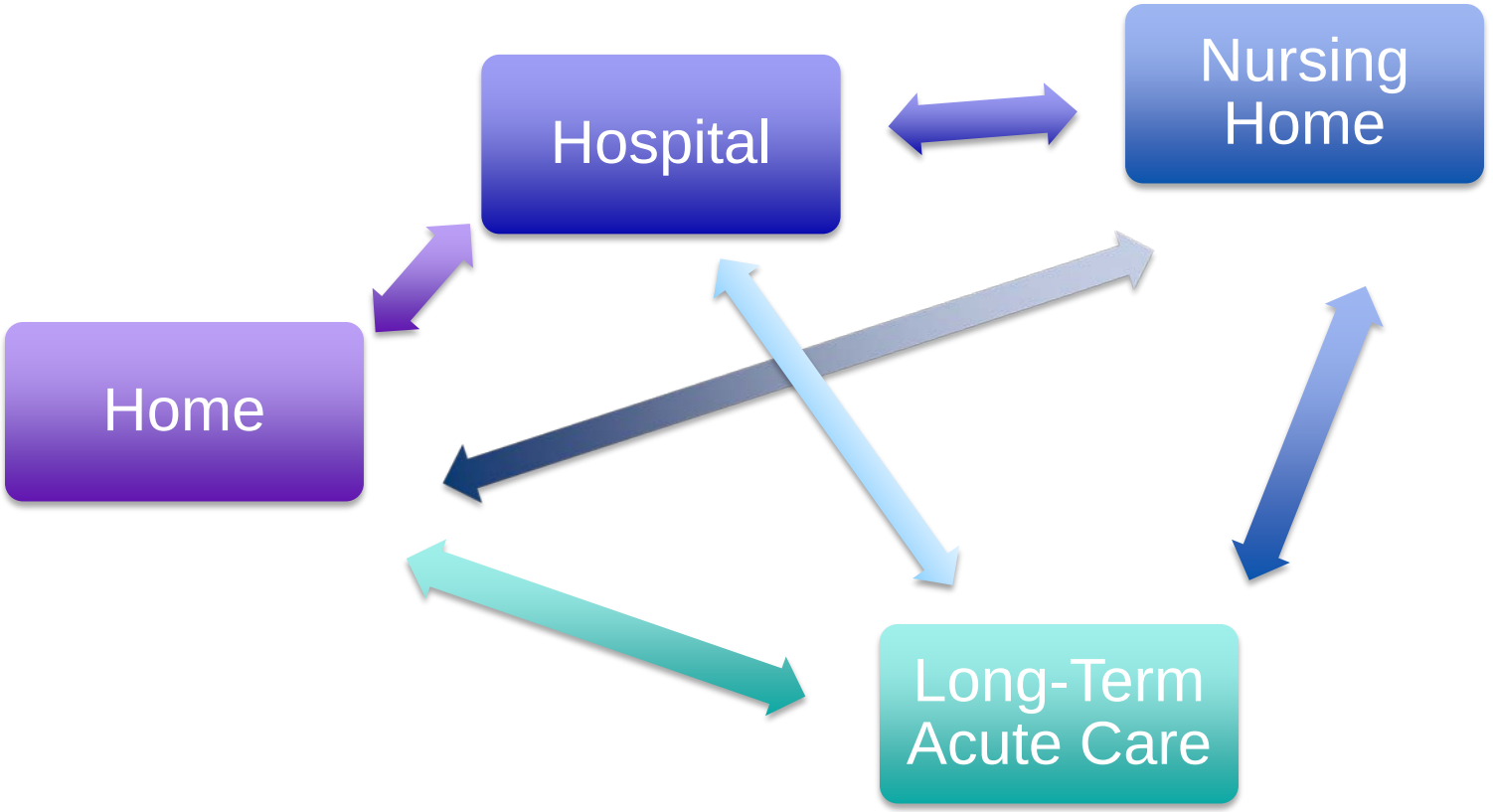
OC Hospitals and Nursing Homes

10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



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Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	**900**	**64%**	**42%**	**16%**	**34%**	**2%**

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

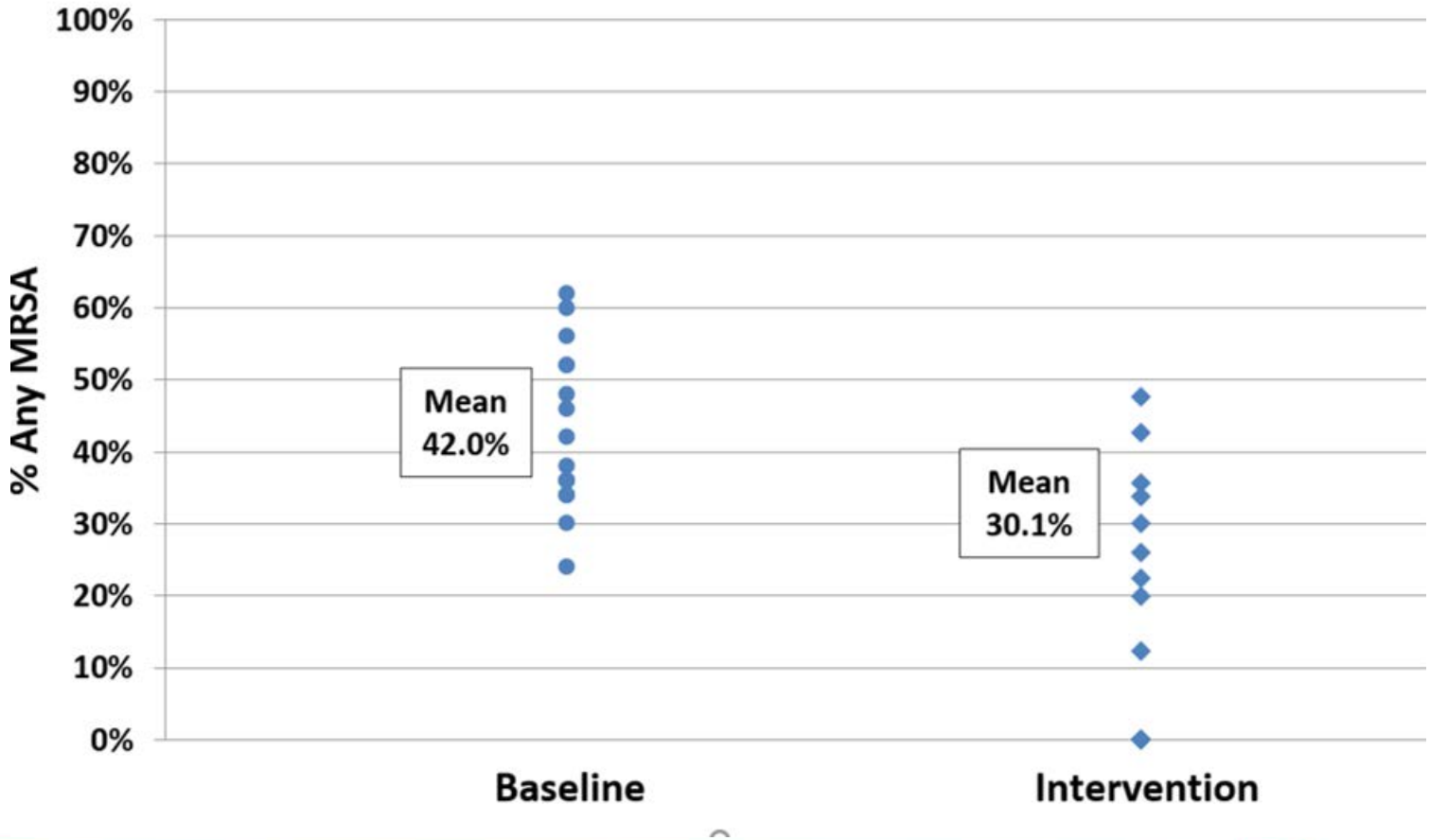
SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - https://www.cdc.gov/hai/research/cdc-mdro-project.html
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

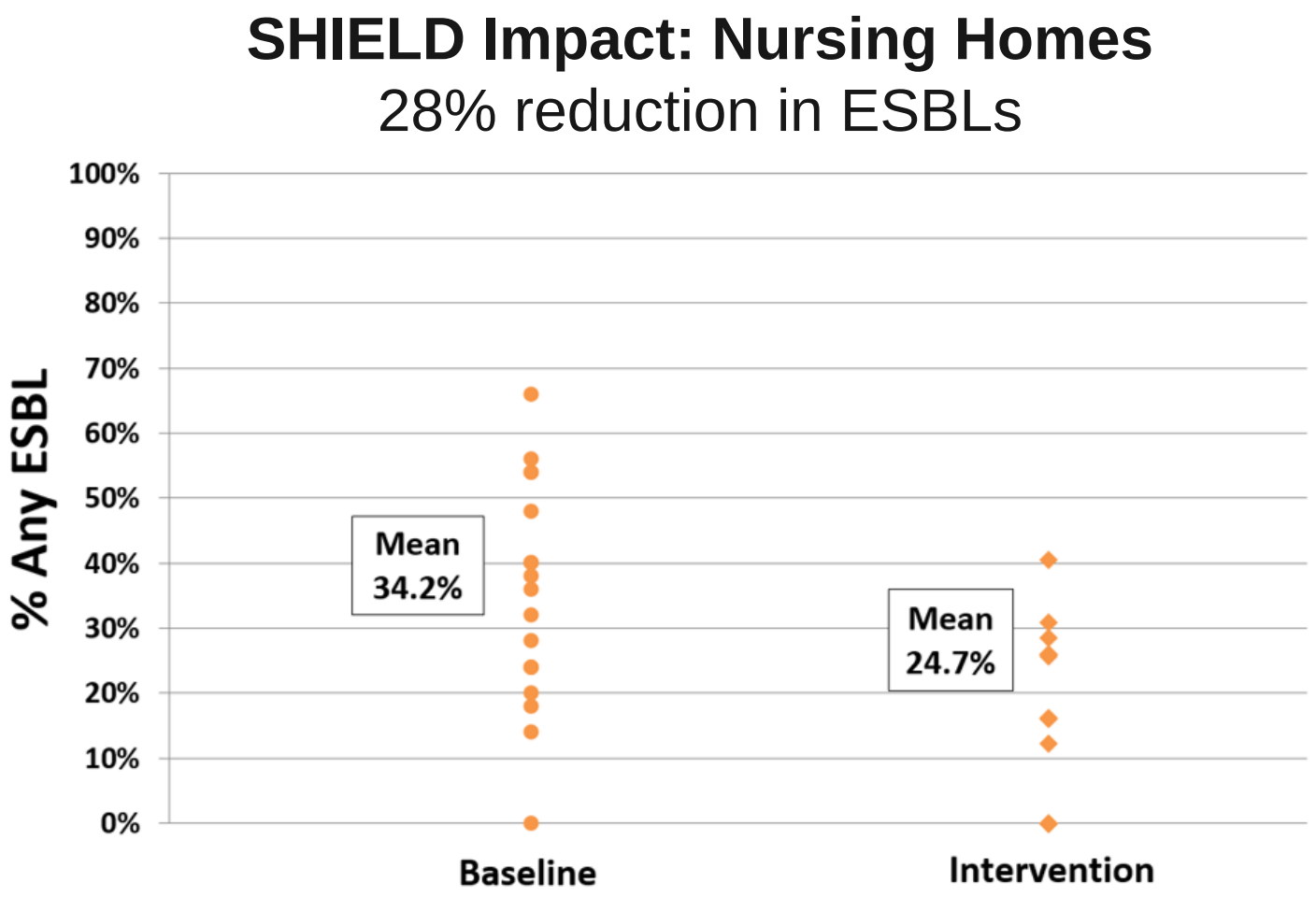
SHIELD Outcomes

SHIELD Impact: Nursing Homes

28% reduction in MRSA



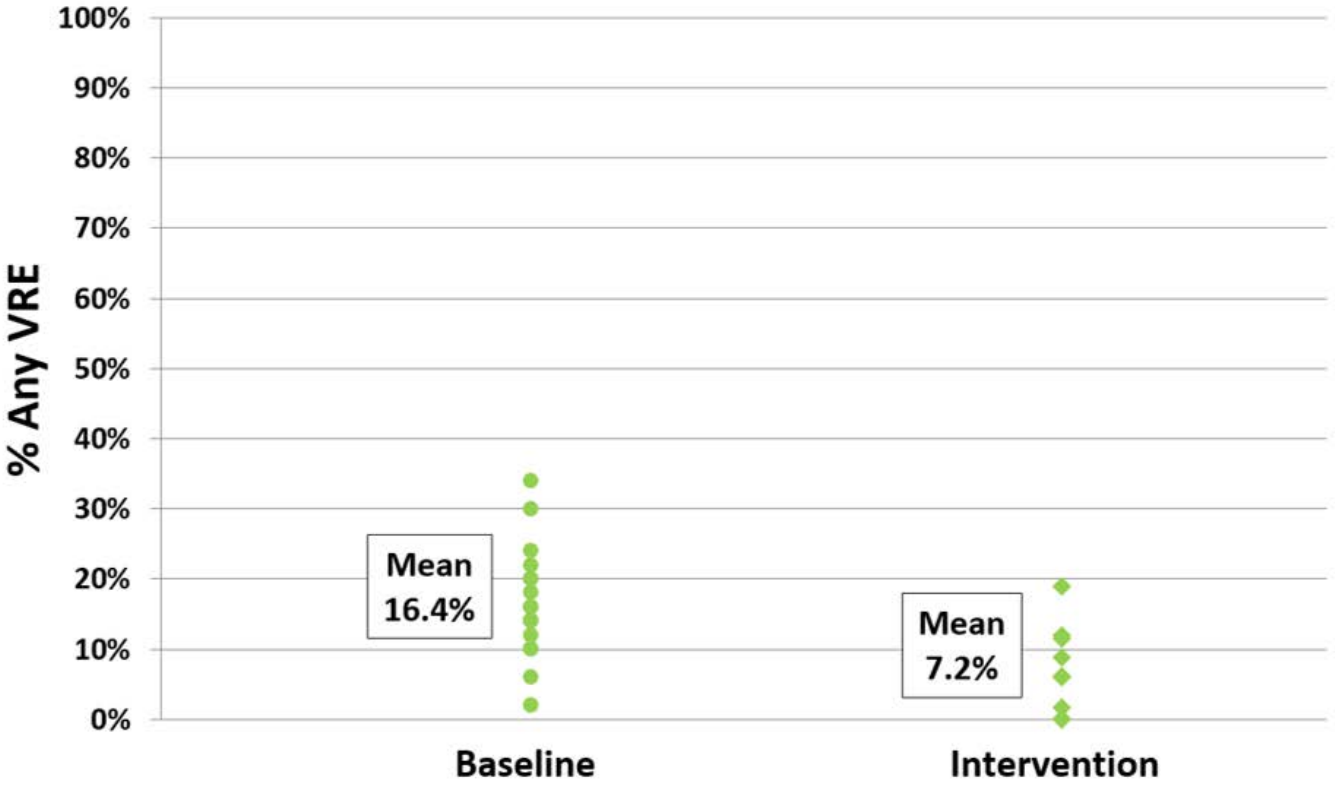
SHIELD Outcomes (cont)



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

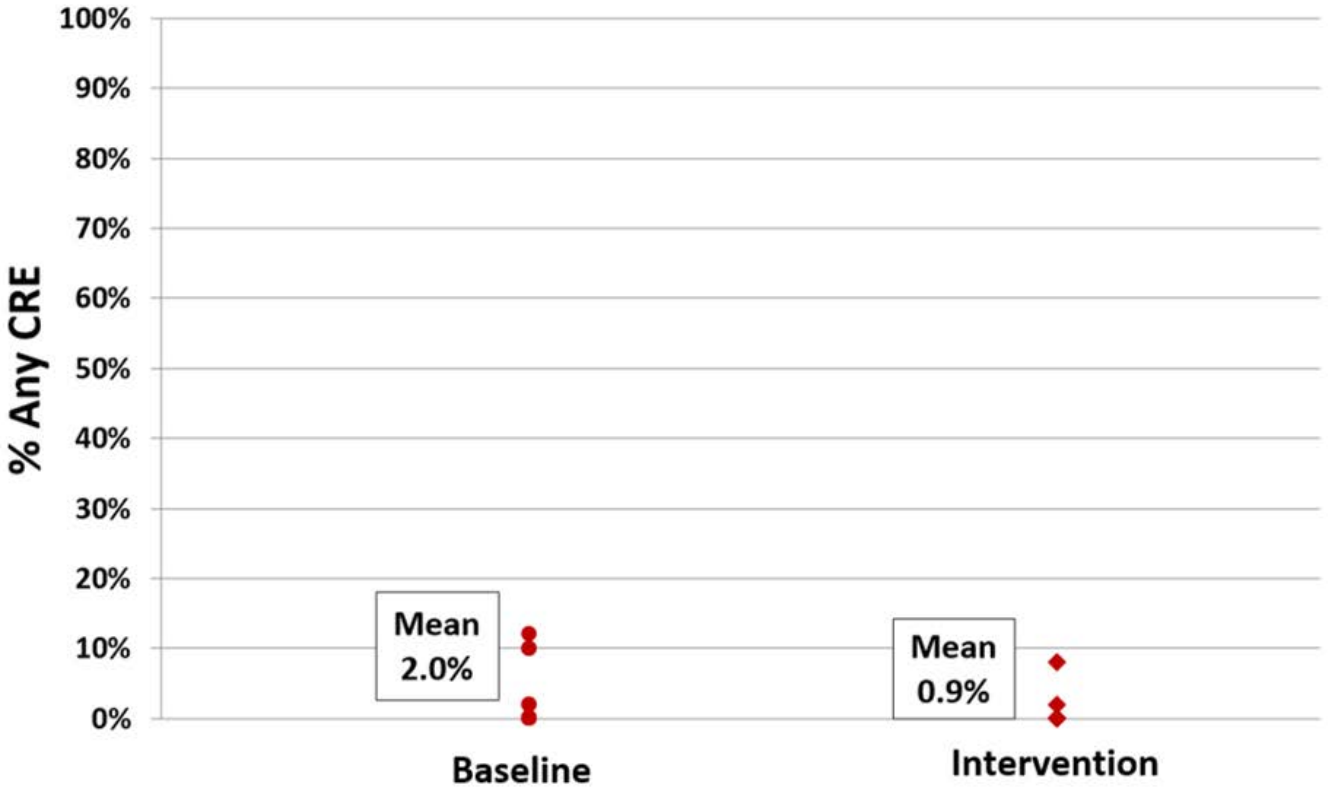
56% reduction in VRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

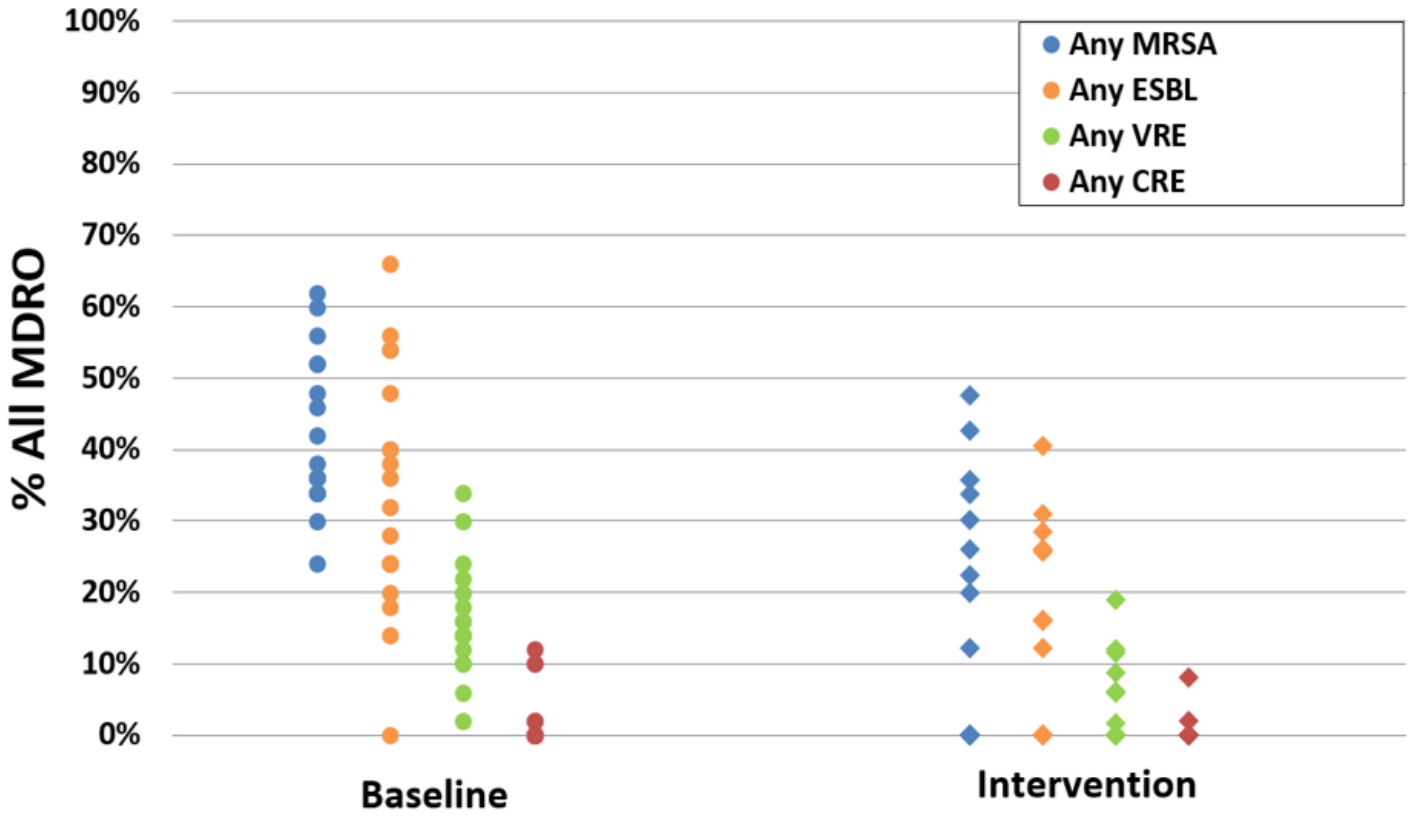
55% reduction in CRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

25% reduction in all MDROs



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Quarterly Inpatient Trends

SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: ORANGE

From: 2015-10 To: 2018-12

Category P - Primary Diagnosis

Select Year-Month Begin	Select Year-Month End	Select Category P Diagnosis Level	Select Risk Group *	Select LTC Facility County
2015-10	2018-12	Category P - Primary Diagnosis	Multiple values	ORANGE

		Before SHIELD OC						During SHIELD OC						
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	$682,769	$854,676	$1,159,922	$920,317	$1,691,337	$1,231,903	$997,810	$1,236,197	$634,628	$979,762	$1,113,238	$1,176,910	$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	$133,362	$311,661	$124,676	$189,669	$227,224	$209,419	$175,738	$164,181	$40,354	$84,565	$127,609	$41,123	$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

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Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = $1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = $468,009
    - $728,002 lowered inpatient expenditure (61%) for infection in the participating facilities

- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters =$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = $3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

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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Shared Healthcare Intervention to Eliminate Life-threatening Dissemination of MDROs in Orange County

SHIELD Orange County – *Together We Can Make a Difference!*

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

Visit our CDC webpage here!
https://www.cdc.gov/hai/research/cdc-mdro-project.html

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team
(949) 824-7806 or SHIELDOrangeCounty@gmail.com

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CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____/_____

Today's Date: _____/_____/_____

Completed by: _____

- ☐ Proof of product purchase
- ☐ Evidence the decolonization program handout is in admission packet
- ☐ Monitor and document compliance with bathing one day each week
- ☐ Monitor and document compliance with iodophor one day each week iodophor is used
- ☐ Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	☐	_____ gallons	_____ gallons
10% Iodine Swabsticks	☐	_____ boxes	_____ boxes
		_____ swabs per box	

INTERNAL USE ONLY –APPROVAL:

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Facility Name: _____Unit: _____ Date: _____

STAFF Skills Assessment:
CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ **Nursing Assistant (CNA)** ☐ **Nurse** ☐ **LVN** ☐ **Other: _____**

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ **Y** ☐ **N** **Resident received CHG bathing handout**
☐ **Y** ☐ **N** **Resident told that no rinse bath provides protection from germs**
☐ **Y** ☐ **N** **Provided rationale to the resident for not using soap at any time while in unit**
☐ **Y** ☐ **N** **Massaged skin *firmly* with CHG cloth to ensure adequate cleansing**
☐ **Y** ☐ **N** **Cleaned face and neck well**
☐ **Y** ☐ **N** **Cleaned between fingers and toes**
☐ **Y** ☐ **N** **Cleaned between all folds**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned occlusive and semi-permeable dressings with CHG cloth**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned 6 inches of all tubes, central lines, and drains closest to body**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on surgical wounds (unless primary dressing or packed)**
☐ **Y** ☐ **N** **Allowed CHG to air-dry / does not wipe off CHG**
☐ **Y** ☐ **N** **Disposed of used cloths in trash /does not flush**

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

_____

2. If more than 6 cloths was used, provide reason.

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

_____

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ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

S.S. Huang, R. Singh, J.A. McKinnell, S. Park, A. Gombosev, S.J. Eells, D.L. Gillen, D. Kim, S. Rashid, R. Macias-Gil, M.A. Bolaris, T. Tjoa, C. Cao, S.S. Hong, J. Lequieu, E. Cui, J. Chang, J. He, K. Evans, E. Peterson, G. Simpson, P. Robinson, C. Choi, C.C. Bailey, Jr., J.D. Leo, A. Amin, D. Goldmann, J.A. Jernigan, R. Platt, E. Septimus, R.A. Weinstein, M.K. Hayden, and L.G. Miller, for the Project CLEAR Trial

ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Huang at the University of California Irvine School of Medicine, Division of Infectious Diseases, 100 Theory, Suite 120, Irvine, CA 92617, or at sshuang@uci.edu.

N Engl J Med 2019;380:638-50.
DOI: 10.1056/NEJMoa1716771

Methicillin-resistant *Staphylococcus aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.[1] It is the most common cause of skin, soft-tissue, and procedure-related infections.[2] Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.[1,3,4]

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.[5,6] Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).[7-10] Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

Methods

Trial Design and Intervention

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge (Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

Recruitment and Eligibility Criteria

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

Follow-up

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits ($25, $30, $35, and $50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.[11] A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)[12] or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine (≥8 μg per milliliter) on microbroth dilution.[13,14] All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the participant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and nonadherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.[15] Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approximately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

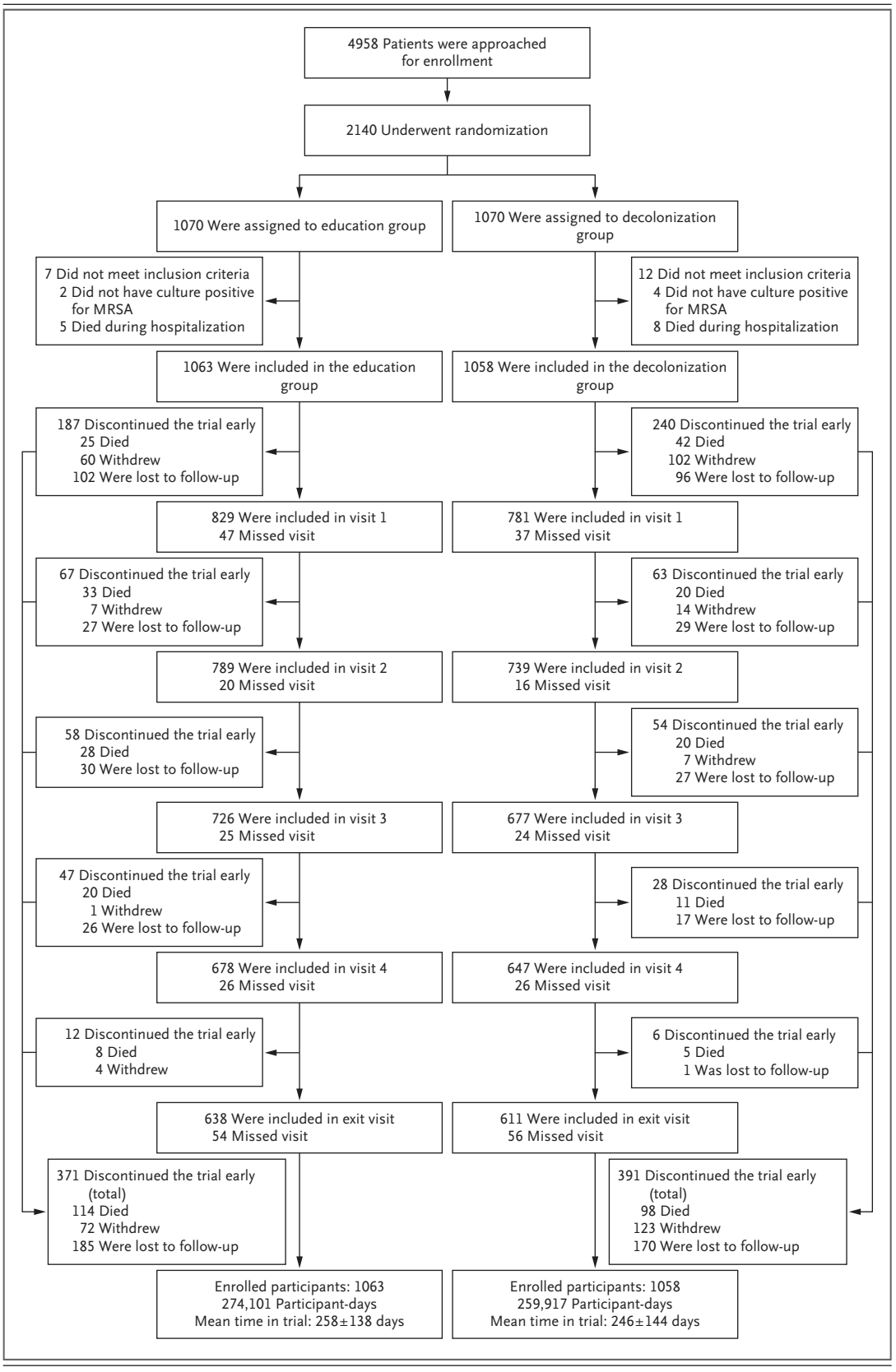

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Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (±SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares‖	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus–minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.
† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.
‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.
§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.
¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.
‖ By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).
** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.
†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.
‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

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Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading in hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.
† This was the primary outcome.
‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96)†	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI)‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI)¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infection was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, P=0.97). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, P=0.82) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care–associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.[16] MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.[1,17-19] In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.[16]

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),[6-10,19-22] a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.[23-26] In contrast, twice-monthly decolonization provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

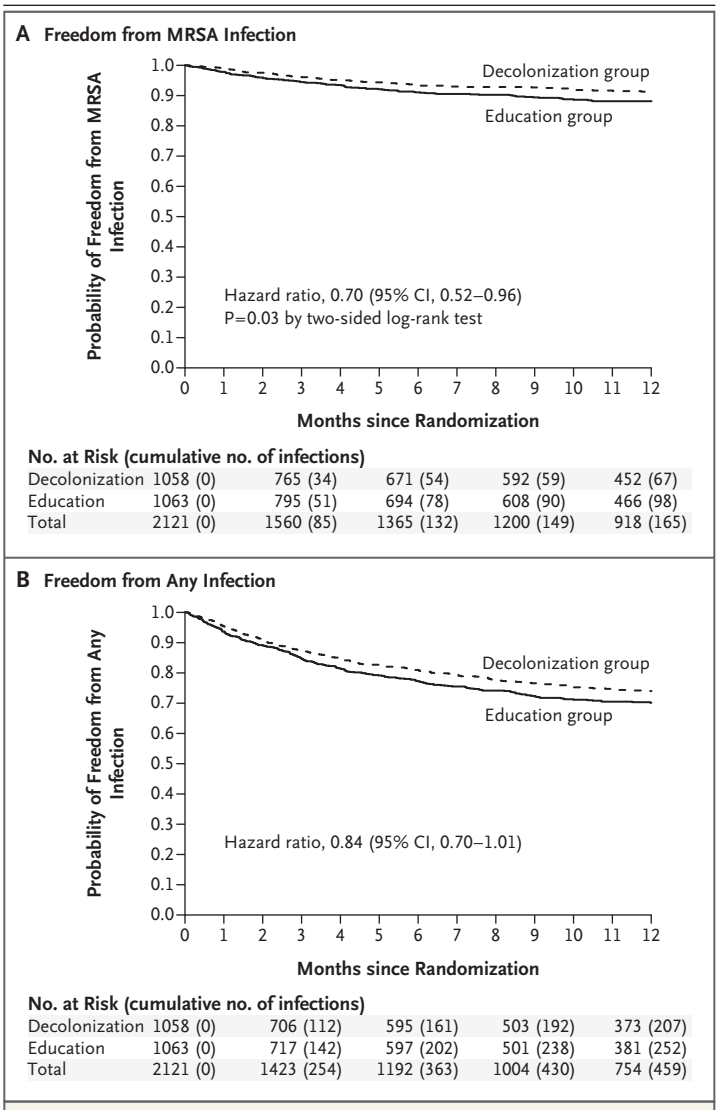

Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

ing and mupirocin application.[8,9,22] This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.[8,9,22]

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.[27-30]

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.[31-33] It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

The authors' full names and academic degrees are as follows: Susan S. Huang, M.D., M.P.H, Raveena Singh, M.A., James A. McKinnell, M.D., Steven Park, M.D., Ph.D., Adrijana Gombosev, M.S., Samantha J. Eells, M.P.H., Daniel L. Gillen, Ph.D., Diane Kim, B.S., Syma Rashid, M.D., Raul Macias-Gil, M.D., Michael A. Bolaris, M.D., Thomas Tjoa, M.P.H., M.S., Chenghua Cao, M.P.H., Suzie S. Hong, M.S., Jennifer Lequieu, B.S., Eric Cui, B.S., Justin Chang, B.S., Jiayi He, M.S., Kaye Evans, B.A., Ellena Peterson, Ph.D., Gail Simpson, M.D., Philip Robinson, M.D., Chester Choi, M.D., Charles C. Bailey, Jr., M.D., James D. Leo, M.D., Alpesh Amin, M.D., Donald Goldmann, M.D., John A. Jernigan, M.D., Richard Platt, M.D., Edward Septimus, M.D., Robert A. Weinstein, M.D., Mary K. Hayden, M.D., and Loren G. Miller, M.D., M.P.H.

The authors' affiliations are as follows: the Division of Infectious Diseases (S.S. Huang, R.S., S.P., D.K., S.R., T.T., C. Cao, S.S. Hong, J.L., E.C., J.C., J.H.), the Health Policy Research Institute (S.S. Huang), and the Department of Medicine (A.A.), University of California Irvine School of Medicine, and the Institute for Clinical and Translational Science (A.G.) and the Department of Statistics (D.L.G.), University of California Irvine, Irvine, the Infectious Disease Clinical Outcomes Research Unit, Division of Infectious Diseases, Los Angeles Biomedical Research Institute at Harbor–UCLA Medical Center, Torrance (J.A.M., S.J.E., R.M.-G., M.A.B., L.G.M.), the Department of Pathology and Laboratory Medicine, University of California Irvine School of Medicine, Orange (K.E., E.P.), Ventura County Medical Center, Ventura (G.S.), the Division of Infectious Disease, Hoag Hospital, Newport Beach (P.R.), the Division of Infectious Disease, St. Mary Medical Center (C. Choi), and MemorialCare Health System (J.D.L.), Long Beach, and the Division of Infectious Disease, Mission Hospital, Mission Viejo (C.C.B.) — all in California; the Institute of Healthcare Improvement, Cambridge (D.G.), and the Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care, Boston (R.P.) — both in Massachusetts; the Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta (J.A.J.); Texas A&M Health Science Center, Houston (E.S.); and Cook County Health and Hospitals System (R.A.W.) and the Division of Infectious Diseases, Rush University Medical Center (R.A.W., M.K.H.), Chicago.

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PUBLIC HEALTH

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 20195:00 AM ET

ANNA GORMAN

A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics. *Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research.

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"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15 percent of hospital patients and 65 percent of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, says Dr. Susan Huang, who specializes in infectious diseases at the University of California, Irvine.
"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or CRE, often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."
Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it.

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The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.
Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused rare but severe allergic reactions.
In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.
In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency
"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.

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Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.
Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.

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"That's right. It protects you from infection."

In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator Shaun Dahl says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says.
Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says**.** "This offers an opportunity to intervene and bend the curve in the right direction."

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USA TODAY

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | **Updated 1:47 p.m. ET April 12, 201**

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.

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USA TODAY

Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. *(Photo: Heidi de Marco, Kaiser Health News)*

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Some of the most common bacteria in health care facilities are methicillin-resistant Staphylococcus aureus, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” E. coli and Klebsiella pneumoniae are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

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Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

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DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

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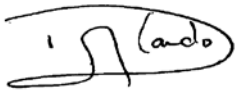
We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,



Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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Attachment 4: IGT Funding Proposals

Proposal 1: Expanded Office Hours

Initiative Description: The Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) is a two-year program to incentivize primary care providers and/or clinics for providing after-hour primary care services to CalOptima members in highly demanded and highly impacted areas. The Expanded Office Hours aims to improve member experience, timely access to needed care, and achieve positive population health outcomes.

Target Population(s): Primary care providers serving CalOptima's Medi-Cal members in highly demanded/impacted areas

Plan of Action/Key Milestones:
High level actions of how CalOptima will invest financial and staff resources to support the Expanded Office Hours initiative, such as:

1. Provider Data Gathering and Internal System Configuration
    - Identify primary care providers in community clinics who serve members in highly demanded and impacted areas
    - Configure the internal system (using codes 99050 and 99051) so claims can be adjudicated, and providers can receive expanded office hour incentives.
        - CPT code descriptions:
            - 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
            - 99051: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
2. Provider Outreach
    - Collaborate with Provider Relations and Health Network Relations to promote the opportunity and encourage providers to provide these services.
    - $125 per member per visit incentive
3. Announce the Expanded Office Hours initiative to impacted Members
    - Call Center and frontline staff training
4. Monitor utilization of the expanded office hour services
    - Monitor and report claims and encounter for identification and linkage to primary care providers providing expanded office hour services

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5. Evaluation
    - Conduct evaluation after pilot to see if member access has improved and depending on the outcome, consider expanding the initiative.

Estimated Budget: Total $2 million (up to $500,000 for FY2019/20, remaining amounts from FY2019/20 and $750,000 for FY2020/21, $750,000 FY2021/22)

Project Timeframe: April 2020 – March 2022

IGT 9 Focus Area: Member access and engagement

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

Participating/Collaborating Partners/Vendors/Covered Entities: Participating providers

Proposal 2: Post-Acute Infection Prevention Initiative (PIPQI)

Initiative Description: Expand CalOptima's program to suppress Multi Drug Resistant Organisms (MDROs) in CalOptima's contracted nursing facilities and decrease inpatient admissions due to infection. The pilot program was approved by CalOptima's Board of Directors on June 6, 2019.

Benefits of the Initiative:

- Member-centric focus: avoid MDRO colonization and inpatient admissions
- Potential cost savings from decreased antibiotic utilization
- Decreased demand for antibiotic-related c. difficile isolation beds
- Decreased Healthcare Acquired Infection rates (HAI):
    - Potential improved Star ratings
    - Strengthens community and national partnerships:
        - UCI (Professor Susan Huang -Department of Infectious Diseases)
        - Matthew Zahn, MD, Orange County Health Care Agency-Division of Epidemiology, CDC
        - (John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention)
        - contracted nursing facilities
        - members/families
- Increased value and improved care delivery
- Enhanced operational excellence and efficiency

*Please note that there is currently an outbreak of a fungal infection called C. auris in Orange County LTACHs and NFs. It's a costly and virulent infection and the Public Health Department is involved. There are currently 160 cases in OC (need updated numbers). Chlorhexidine eradicates and protects against this fungus as well as Multi Drug Resistant Organisms (MDROs)

Target Member Population(s): CalOptima Members receiving services at contracted nursing facilities

Plan of Action/Key Milestones:

A. Teleconference requested by the CDC scheduled for April 2, 2020, as CalOptima is the only County in the U.S. that is an early adopter of CHG/Iodophor in NFs to lower MDRO colonization rates

B. Dedicate two Long Term Support Services Nurses to:

1) Provide training for newly participating facilities,
2) Provide ongoing support and compliance monitoring* at all participating facilities,
3) Develop additional informing, training and monitoring materials.

C. Promote the expansion of the Post-Acute of Infection Prevention Program and engage nursing facility administration and staff at the March 20, 202 LTSS Workshop.

*Monitoring includes monthly random testing (five patients per facility confirming presence of Chlorhexidine, invoices /delivery receipt for Chlorhexidine and Iodophor). Additional metrics: acute inpatient admission rates due to infection, Hospital Acquired Infection (HAI) rates.

Estimated Budget: Total budgeted amount $3.4 million over 3 fiscal years ($1 million for FY2019/20, $1.2 million for FY 2020/21 and $1.2 million for FY 2021/22)

Project Timeframe: Three years FY 2019/20– 2021/22

IGT 9 Focus Area: Quality performance and data exchange and support

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Expand CalOptima's Member-Centric Focus, Strengthen Community Partnerships, Increase Value and Improve Care Delivery, Enhance Operational Excellence and Efficiency.

Participating/Collaborating Partners/Vendors/Covered Entities: University of California Irvine Medical Center, Department of Infectious Disease, Dr. Susan Huang; Orange County Health Care Agency-Division of Epidemiology, Centers for Disease Control (CDC); John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention; CalOptima contracted nursing facilities.

Proposal 3: Hospital Data Sharing Initiative

Initiative Description: Establish incentives for implementation of a data sharing solution for Admit, Discharge, Transfer (ADT) and Electronic Health Record data to support alerting of hospital activities for CalOptima members for the purposes of improving care management. Participating entity will be eligible for incentive once each file exchange is in place. The overall goal is to improve costs, quality, care, and satisfaction.

Target Population(s): Contracted and participating Orange County hospitals serving CalOptima members and, potentially, other Community Based Organizations within the delivery system

Plan of Action/Key Milestones: Staff will obtain Board of Directors approval, contract with selected vendors, implement the solutions, establish an incentive plan and details, and work with the vendors and the hospitals to establish the means of sharing data.

Estimated Budget: $2 million to be exhausted by end of FY 2020-2021

Project Timeframe: Until end of FY 2020-2021

IGT 9 Focus Area: Data exchange and support

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus and Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: Hospitals providing the requested data

Proposal 4: Intergovernmental Transfer (IGT) Program Administration

Initiative Description: Administrative support activities related to prior, current and future IGTs opportunities, grants, internal initiatives. This will continue support for management of the IGT transaction process, project and expenditure oversight related to prior IGTs (outstanding grants and internal projects), as well as current IGTs in progress (i.e., IGTs 9 and 10) and oversight. Administration will be consistent with CalOptima standard policies, procedures and practices and will ensure funding investments are aligned with CalOptima's strategic priorities and member needs. Two staff positions, the Grant Management System license, public activities and other administrative costs are included.

Target Member Population(s): NA

Plan of Action/Key Milestones: NA

Estimated Budget: $2,000,000

Project Timeframe: Five–years

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Strengthen Community Partnerships, Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: NA

Proposal 5: Whole Child Model (WCM) Program

Initiative Description: To fund WCM program deficit in year one

Target Member Population(s): WCM eligible members (12,000 to 13,000)

Plan of Action/Key Milestones: N/A

Estimated Budget: Total $31.1 million for FY 2019-20

Project Timeframe: FY 2019-20 (July 1, 2019 to June 30, 2020)

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives:
To Support care delivery for WCM population in FY 2019-20

1) Insufficient revenue from DHCS
2) Complexity in operation and financial reconciliation

Participating/Collaborating Partners/Vendors/Covered Entities: N/A

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

Contact

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions

1. Approve Virtual Care Strategy and Roadmap;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with vendor mPulse Mobile, a Mobile Health Interactive Text Messaging Services vendor; and
3. Approve the recommended allocation of intergovernmental transfer (IGT) 9 funds not to exceed $3.9 million for a three-year period to provide a text messaging solution for all CalOptima member communications.

Background

As the Coronavirus Disease (COVID-19) continues to spread and threatens lives of many vulnerable populations, the COVID-19 pandemic has created an urgency for CalOptima and other Managed Care Plans (MCPs) to expand their virtual care strategy immediately to ensure timely access to care for our members and support our providers' use of virtual care during the strict social distancing measures while providers experience shortages of Personal Protective Equipment (PPE).

As a result of the COVID-19 pandemic, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements.

At its April 2, 2020 meeting, the CalOptima Board of Directors ratified various COVID-19 mitigation activities. In addition to the approval of Telehealth Policies and Procedures to include temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements in the event of a health-related national emergency, the Board authorized contracting with Virtual Care Consultant Sajid Ahmed of WISE Healthcare to help expedite the deployment of the CalOptima Virtual Care Strategy and Roadmap.

At the same meeting, the Board approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas. At that time, the Board approved five initiatives totaling $40.5 million. Staff would return to the Board with recommendations for allocating the remaining $4.5 million towards member access and engagement.

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Discussion

In addition to the actions approved in response to COVID-19 to date, management recommends that the Board authorize the implementation of virtual care services for members and providers with long term implications beyond the COVID-19 pandemic.

Virtual Care Strategy and Roadmap

As the sophistication and simplification of mobile technology has evolved over time beyond telehealth, virtual care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring, and treatment. CalOptima staff cites to an adopted virtual care definition as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care." [1]

CalOptima management plans to continue to use the term "telehealth" to include member materials approved by DHCS in order to be consistent with DHCS All Plan Letter (APL) 19-009: Telehealth Services Policy.

CalOptima's main Virtual Care Strategies include the following elements. Staff will return to the Board to seek authority for approval of implementation of the Virtual Care Strategies through specific vendors and initiatives in the future:

1. Support CalOptima's contracted providers' use of virtual visits during COVID-19 and beyond [all members]
    a. Technical assistance and operational support
    b. CalOptima virtual care team
    c. HIPAA compliant platform(s)
2. Contract with specialty providers with a virtual care focus for CCN members.
    a. Provider(s)/vendor(s) to treat chronic pain/opioid dependency, and provide medication assisted treatment, and eating disorder treatment
    b. Other specialties as available
3. Contract with a vendor offering virtual visits including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions through its own provider network
    a. Integrate with CalOptima website and/or member portal
    b. Technical support for members
    c. Integrate with existing nurse advice line
    d. Develop member smartphone app
4. Contract with a vendor offering eConsults for CCN members and PCP's through CalOptima contracted specialists who wish to participate and/or its own provider network
    a. Technical assistance and operational support for CCN providers
    b. Integrate with CCN UM process
    c. Integrate with CCN provider portal
5. Member texting
    a. Via CalOptima member smartphone app

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With these proposed Virtual Care Strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits:

- Improved member access and convenience;
- Reduced avoidable in person visits to specialists; and
- Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care:

- Improved member experience;
- Augmented network capacity and adequacy; and
- Improved clinical quality outcomes.

As recommended by staff, CalOptima's Virtual Care Strategy proposes a detailed logic model and a work plan which are included in the attachments (refer to Attachment 3 and Attachment 4).

Proposal to Implement Mobile Health Interactive Text Messaging Services

CalOptima currently uses traditional modes of member communication, including telephonic, print and mail. CalOptima staff seeks to strengthen communication outreach opportunities to our members through Mobile Health Interactive Text Messaging Services that will:

- Deliver useful health promotion and prevention messaging;
- Promote healthy behaviors among members;
- Facilitate behavior change;
- Provide support through impactful media;
- Promote wellness and preventive care including Healthcare Effectiveness Data and Information Set (HEDIS) measures;
- Improve clinical outcomes; and
- Encourage adherence to recommended care practices

CalOptima's RFP minimum requirements for the mobile texting vendor include the following:

- Provide Mobile Text Messaging services to enhance member engagement by supporting CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.
- Deliver technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.
- Ensue that content written at a sixth grade reading level or below so that the information is easy to understand.
- The Platform must be a Health Insurance Portability and Accountability Act (HIPAA) compliant platform with secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data.

Through a Request for Proposal (RFP) process conducted in 2019, CalOptima staff received eight (8) responses and with two finalist texting solution vendors, HealthCrowd and mPulse Mobile (mPulse). CalOptima's Mobile Texting RFP Selection workgroup is recommending that the Board authorize a

contract with mPulse based on it receiving the highest evaluation score (refer to Attachment 5) mPulse specializes in Conversational Artificial Intelligence (AI) solutions for the healthcare industry and promotes improved health outcomes by engaging individuals with tailored and meaningful dialogue. mPulse combines behavioral science, analytics and industry expertise to help healthcare organizations promote their members acquiring healthy behaviors. mPulse is HIPAA and Telephone Consumer Protection Act (TCPA)-compliant, and Health Information Trust (HITRUST) Alliance-certified.

CalOptima's Mobile Texting RFP Selection workgroup is recommending Board authorization for a contract of three years in an amount not to exceed $3,900,000. Based on the CalOptima membership, the estimated annual cost for the contract is approximately $1,000,000, with a separate expense of $80,256 for implementation and set-up. Staff recommends allocating IGT 9 funding not to exceed $3.9 million under the Board-approved focus area of Member Access and Engagement. In addition, staff recommends entering into further negotiations and pursing a contract with mPulse with the assistance of CalOptima's Procurement and Legal Departments.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from the DHCS in that, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's General and Administrative categories, which are included in administrative loss ratio (ALR).

DHCS requires MCPs to submit a texting program and/or its individual texting campaign approval form to the state. DHCS will review and respond within 60 days of submission of the form (See Attachment 7).

As indicated, staff will return to the Board to seek authority for approval of other elements of the Virtual Care Strategy in the future.

Fiscal Impact

The recommended action to approve the Virtual Care Strategy and Roadmap has no additional fiscal impact for Fiscal Year (FY) 2019-20. Staff will address new virtual care strategies including a vendor offering 24/7 virtual visits and a vendor offering eConsults in future board reports and recommended actions.

The recommended action to select and contract with mPulse, a mobile health interactive text messaging services vendor has no net fiscal impact to CalOptima's operating budget over the proposed project term. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures for the initiative recommended in this report.

Rationale for Recommendation

The recommended actions are important steps in enabling CalOptima to provide additional access to quality care for our members and providers during and after the pandemic.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities
2. CalOptima Virtual Care Roadmap Presentation
3. Virtual Care Strategy Logic Model
4. Virtual Care Strategy Work Plan
5. 19-20 Texting RFP Final Team Evaluation Summary Scoring Criteria
6. Texting Program RFP Scope of Work
7. DHCS Texting Program & Campaign Submission Form
8. Board Action dated February 7, 2019, Consider Approval of CalOptima Population Health Management Strategy for 2019
9. Entities Covered by this Recommended Board Action

Reference
1. Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

/s/ Richard Sanchez — *04/29/2020*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact
David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions
1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)
One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

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Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

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The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

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- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

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Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

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PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Term	Definition
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department, located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

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Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

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G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

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provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

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

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
www.dhcs.ca.gov

If you have any questions regarding this supplemental guidance, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

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- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

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PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

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its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

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- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. Data Architect

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

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- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

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Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

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Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

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PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

E-MAIL PSCHEID12@GMAIL COM
17 CALLE FRUTAS, SAN CLEMENTE, CA 92673
(714) 227-4123 CELL
(949) 229-7684 FAX

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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting **Feb. 2020 – Present**

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California **April 2017 – Feb. 2020**

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

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- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

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- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

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*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

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Virtual Care Strategy: Road Map to Increase Access to Care

Board of Directors Meeting

May 7, 2020

Sajid Ahmed, CEO WISE Healthcare, CalOptima Virtual Care Expert

Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality & Population Health Management

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On Strategy

"For some organizations, near-term survival is the only agenda item.

Others are peering through the fog of uncertainty, thinking about how to position themselves once the crisis has passed and things return to normal.

Crisis

危機

A time of danger

A time of opportunity

The question is, 'What will normal look like?' While no one can say how long the crisis will last, what we find on the other side will not look like the normal of recent years."

~ Ian Davis, 2009

During the Great Recession

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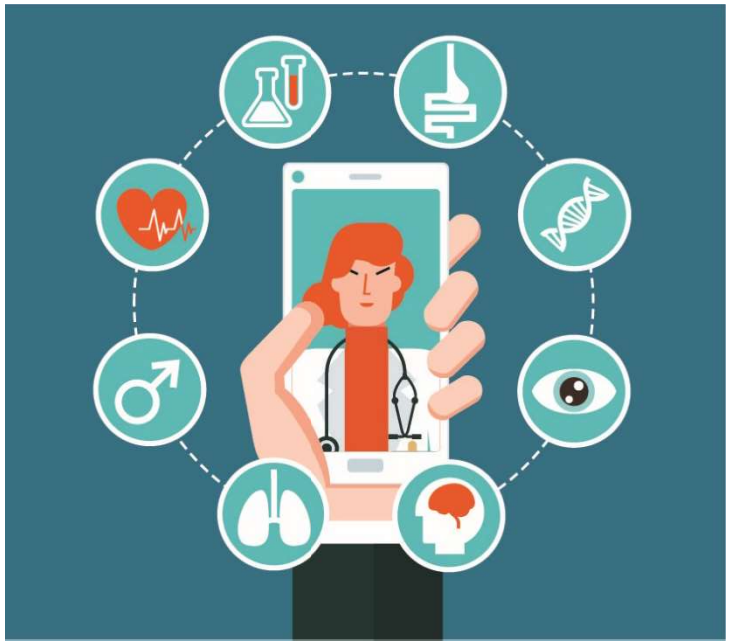
Agenda

- Traditional Barriers to Telehealth
  - Impact of COVID-19 on Regulations
- Virtual Care Definition (Telehealth)
- Virtual Care Modalities
- Virtual Care Roadmap Approach
  - Logic Model: Virtual Care Adoption for CalOptima
- The Future
  - Lifting of Barriers
  - Will They Stay or Will They Go Now?
- CalOptima Virtual Care Strategy



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Traditional Barriers

- Payment and compensation (Provided due to COVID-19)
- Disruptive to current workflow (Yes, post COVID-19)
- Got enough on my plate (COVID-19 response is priority)
- Their convenience, not mine (COVID-19 response is priority)
- New technology, learning (Not really but in some cases)
- Laws, rules, and regulations (Relaxed due to COVID-19)
- Liability questions (Telehealth Insurance now standard)

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Impact of COVID-19 on Regulations

- On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a pandemic.
- On March 15, Health and Human Services issued a "limited waiver" of Health Insurance Portability and Accountability Act sanctions.
- On March 17, Centers for Medicare & Medicaid Services said it would expand Medicare coverage of telemedicine services.
  - CMS said Medicare will pay providers the same in-person rates for virtual visits with hospitals, doctors and other licensed clinicians […] regardless of the patients' location.
- And on and on ...

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Virtual Care Definition

- Beyond telehealth, Virtual Care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring and treatment.

- A recent paper offered the following definition of virtual care:
  - Any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care.

By Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

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Virtual Care Modalities

	Real Time "Synchronous"	**Store and Forward** "Asynchronous"
Visits (Provider to Patient)	**Virtual Visit**  Video/telephonic visit between provider and patient	***e*Visit**  Online exchange (e.g., email or text) between provider and patient
Consults (Provider to Provider)	**Virtual Consult**  Video/telephonic consult between provider to patient's provider	***e*Consult**  Online consult between specialist to patient's local provider

Virtual Care **IS** care provided via phone, email, text, and video.
87% of all diagnostic decisions can be made via Virtual Care

Image courtesy of Sajid Ahmed at WISE Healthcare.

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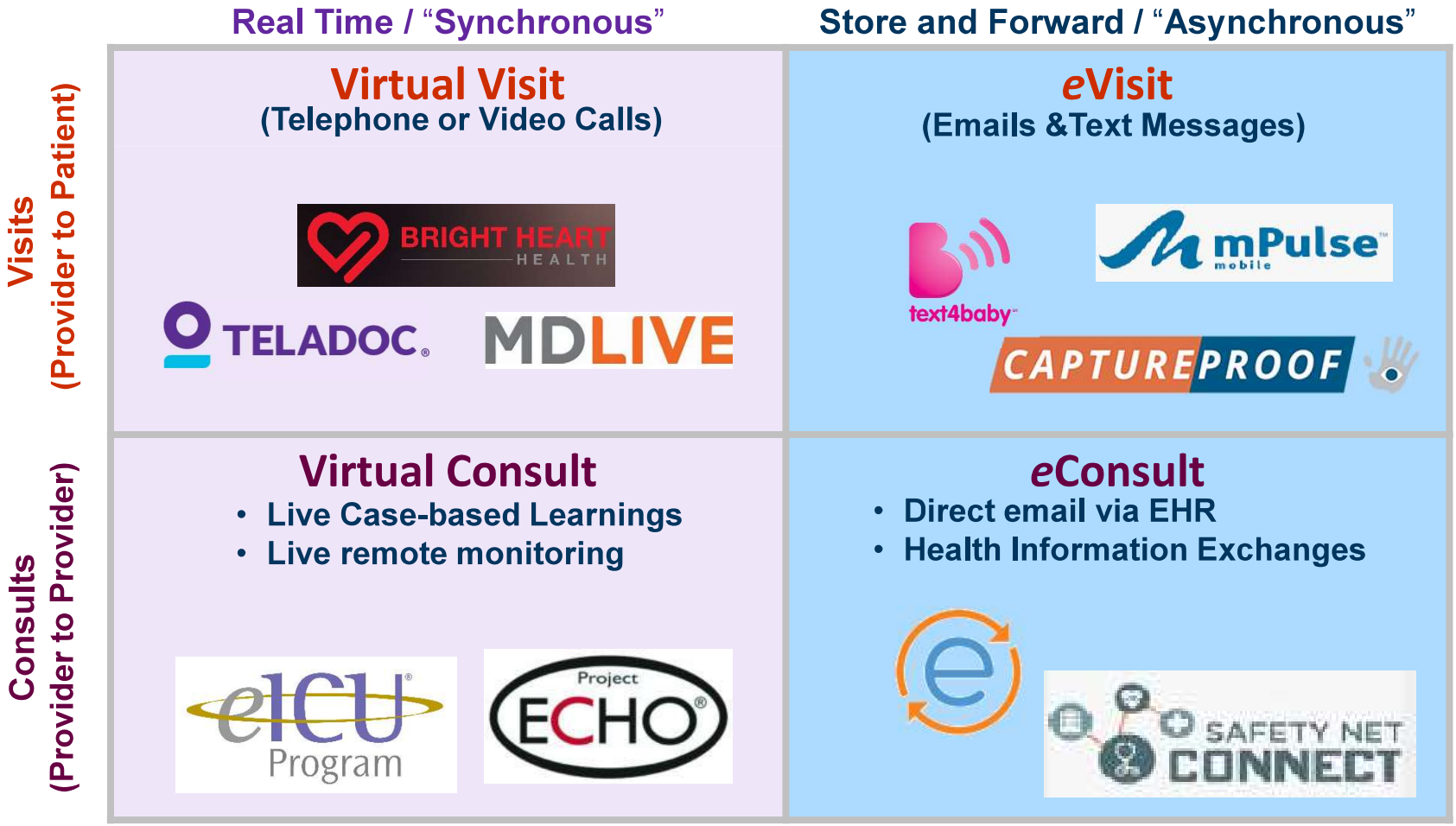
Examples of Virtual Care Modalities



Examples only. CalOptima does not endorse specific vendor.

Image courtesy of Sajid Ahmed at WISE Healthcare.

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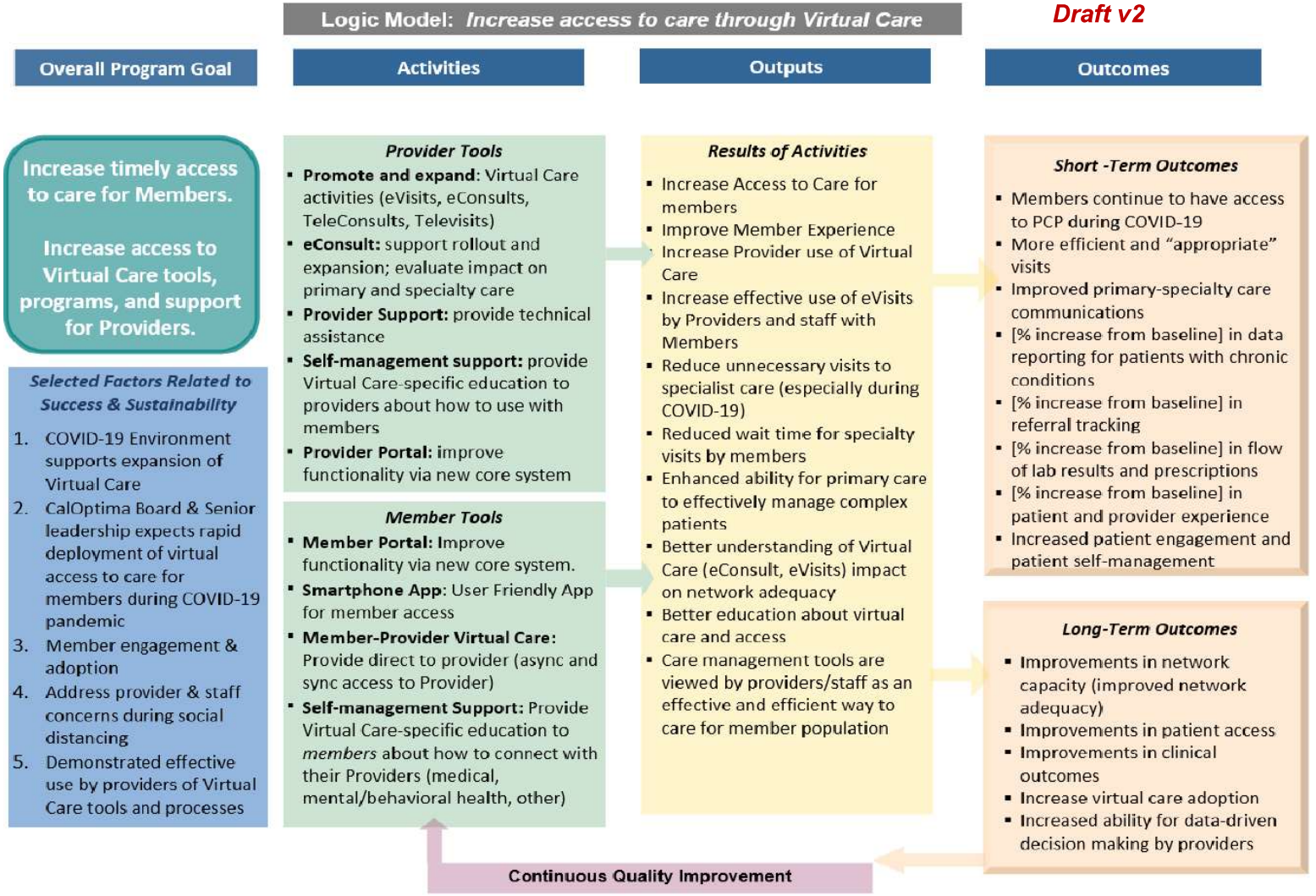
Logic Model: Increase Access to Care Through Virtual Care



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MCP Guidance for Use of Virtual Care by Members and Contracted Providers (cont.)

Member

- Member will use the provider-given cell number to **text** the provider with their reason to request a virtual visit (chief complaint, medical concern, follow-up visit).
- Provider and member will communicate back and forth using text messages (member to provider eConsult).
  - If member concerns are resolved at this stage, no further action is necessary.
- If the provider deems a phone **call** necessary, text messages will be used to coordinate the call.
  - With all stages of communication, the provider can use any location (home) as a responding site.
- If after the phone conversation the provider deems that a **video call** would be necessary, text messages are used to coordinate a video call.

Disclaimer: MCPs do not recommend, endorse, nor sponsor specific messaging applications nor cellular providers.

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MCP Guidance for Use of Virtual Care by Members and Contracted Providers

Due to COVID-19, select federal and state virtual care restrictions have been lifted — the use of smartphones and other communication applications to facilitate dialogue between providers and members has been approved. This communication will be allowed and reimbursable per CMS and DHCS directives.

Protocol: Providers and members can text, call and video call to coordinate and manage care to and from any location (home).

Providers

Providers will select a SMS text enabled cell number that can be used by patients. If possible, this can be the provider's primary cell number or:

- An app can be used that allows the provider to receive multimedia messages (WhatsApp, iMessage, Line, GroupMe, Google Duo, Arya, etc.)
- Providers can obtain a new cell number to be used for this purpose through any cellular carrier

Providers can designate a staff member to monitor communication with this number (possibly through a group chat) and facilitate member provider coordination.

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Every Cloud Has a Silver Lining...

- It took the COVID-19 pandemic to
  - Waive or relax most health care regulations to ensure that patients get the best possible care at the lowest possible cost, when and where they need it.
- The federal rules and regulations providing limited waivers due to the COVID-19 pandemic are:
  - **HIPAA sanctions waiver —** waiving patient consent
  - **Telemedicine reimbursement —** provided for all virtual care
  - **Physician scope of practice** — lets "all doctors and medical professionals to practice across state lines to meet the needs of hospitals that may arise in adjoining areas"
  - **Elective surgery guidance** — limits elective surgical and dental procedures for adults
  - **Quality reporting requirements —** suspended or extended

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Regulations: Will They Stay, or Will They Go?

- The outbreak shined a light on all the rules and regulations that the U.S. health care system operates under.
- Regulations and rules shown to be impediments to safe, effective, convenient, accessible and affordable care for members.
- CalOptima's long term Virtual Care strategy provides a roadmap to navigate the future in providing low-cost, high quality, timely access to care.

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Key Takeaways

- COVID-19 morphed virtual care into a powerful resource that enables the disruption of health care delivery.
- In-person care and virtual care are to be treated the same as appropriate. With virtual care expected to be the primary modality to access care in the future.
  - The “new normal”
- Leadership support is needed from the Board, Chiefs, physician champions, and Health Networks to achieve success and meet the challenges and opportunities of the health care “new normal”

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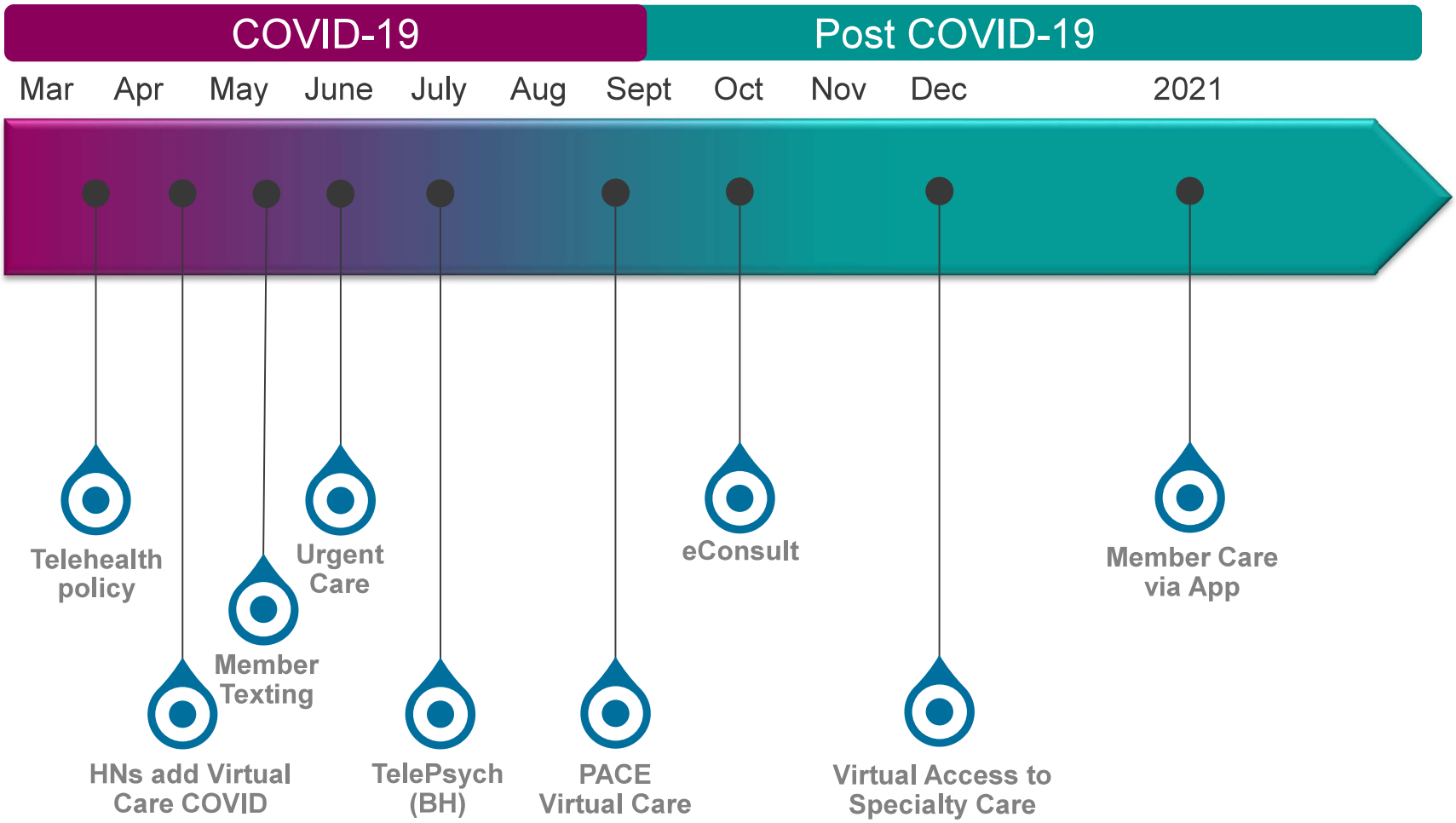
High Level Virtual Care Roadmap



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CalOptima Virtual Care Strategy (Road Map)

Board of Directors Regular Meeting

May 7, 2020

David Ramirez, M.D., Chief Medical Officer

Betsy Chang Ha, RN, MS, LSSMBB

Executive Director, Quality & Population Health Management

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Back to Agenda

Virtual Care Guiding Principles

- Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management;
- Leverage existing delivery model where possible;
- To be proactive in seeking out opportunities to innovate; and
- To provide technology-agnostic solutions.

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Proposed Initial Virtual Care Strategy: All Members (HN/CCN/COD)

Member to Provider		
Goals	**Use Existing Network Providers**	**Contract Vendor(s) to support limited scope of services during COVID-19**
Tasks	• Leverage existing capabilities • Guidance • Technical support • Technology agnostic	• Member self-referral via Member Portal (web) • Urgent care • Prescription management • Access to Behavioral Health
Time	Q1 2020	Initiate Contract in Q2–Q3 2020
Action	**Update Telehealth Policy (completed)**	**RFP (IGT 9) for vendor(s)**

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Proposed Initial Virtual Care Strategy: CalOptima Community Network & CalOptima Direct

	Member to Provider	Provider to Provider
Goals	**Provide Virtual Care:** Member access to Provider Group(s), eVisits to primary care and specialist services	**Implement eConsult (CCN)** (Provider to Provider) per DHCS APL 19-009 to provide eConsult as a covered benefit
Tasks	• Support existing physical primary care providers and specialists • Behavioral Health Services (for all members) • Expand specialty providers with a virtual care focus	• Prior Authorization process modified to allow eConsult to replace authorization • Make available to PACE as well • Provider self-service and submit authorization via Provider Portal and eConsult
Time	Selection in Q3 2020	Contract in Q4 2020
Action	**Evaluate telehealth providers/groups**	**Develop plan to implement eConsult**

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Virtual Care Roadmap Q2–Q4

High Level Activities

1. Member engagement approaches, app support and tools
2. Continue activities to support COVID-19 related items
3. Virtual Care technical platform for PACE
   - Facilitate provider-member virtual visits
4. Investigate and implement provider support and technical assistance
5. In progress:
   - Virtual Care Strategy and Roadmap
   - CalOptima Virtual Care Team
6. Expand specialty providers with a virtual care focus
   - Behavioral health and other specialties

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Virtual Care Roadmap Q2–Q4 (cont.)

High Level Activities (cont.)

7. Offer 24/7 virtual visits (after-hour access)
   - Acute non-emergency medical conditions
   - Behavioral health conditions
8. Investigate and implement CalOptima member engagement access via member portal app
   - APIs to virtual visits, eVisits, secure messaging
9. Plan and launch eConsult/eReferral program for CCN
10. Member texting
    - E.g. Text For Baby, notifications, alerts via CalOptima Smart app, e.g. IEHP Smart Care app
11. RFP for member direct to provider access
    - Member to provider

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Logic Model: *Increase access to care through Virtual Care*

Draft v2

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Overall Program Goal

Increase timely access to care for Members.

Increase access to Virtual Care tools, programs, and support for Providers.

Selected Factors Related to Success & Sustainability

1. COVID-19 Environment supports expansion of Virtual Care
2. CalOptima Board & Senior leadership expects rapid deployment of virtual access to care for members during COVID-19 pandemic
3. Member engagement & adoption
4. Address provider & staff concerns during social distancing
5. Demonstrated effective use by providers of Virtual Care tools and processes

Activities

Provider Tools

- **Promote and expand**: Virtual Care activities (eVisits, eConsults, TeleConsults, Televisits)
- **eConsult:** support rollout and expansion; evaluate impact on primary and specialty care
- **Provider Support:** provide technical assistance
- **Self-management support:** provide Virtual Care-specific education to providers about how to use with members
- **Provider Portal:** improve functionality via new core system

Member Tools

- **Member Portal:** Improve functionality via new core system.
- **Smartphone App**: User Friendly App for member access
- **Member-Provider Virtual Care:** Provide direct to provider (async and sync access to Provider)
- **Self-management Support:** Provide Virtual Care-specific education to *members* about how to connect with their Providers (medical, mental/behavioral health, other)

Outputs

Results of Activities

- Increase Access to Care for members
- Improve Member Experience
- Increase Provider use of Virtual Care
- Increase effective use of eVisits by Providers and staff with Members
- Reduce unnecessary visits to specialist care (especially during COVID-19)
- Reduced wait time for specialty visits by members
- Enhanced ability for primary care to effectively manage complex patients
- Better understanding of Virtual Care (eConsult, eVisits) impact on network adequacy
- Better education about virtual care and access
- Care management tools are viewed by providers/staff as an effective and efficient way to care for member population

Outcomes

Short -Term Outcomes

- Members continue to have access to PCP during COVID-19
- More efficient and "appropriate" visits
- Improved primary-specialty care communications
- [% increase from baseline] in data reporting for patients with chronic conditions
- [% increase from baseline] in referral tracking
- [% increase from baseline] in flow of lab results and prescriptions
- [% increase from baseline] in patient and provider experience
- Increased patient engagement and patient self-management

Long-Term Outcomes

- Improvements in network capacity (improved network adequacy)
- Improvements in patient access
- Improvements in clinical outcomes
- Increase virtual care adoption
- Increased ability for data-driven decision making by providers

Continuous Quality Improvement

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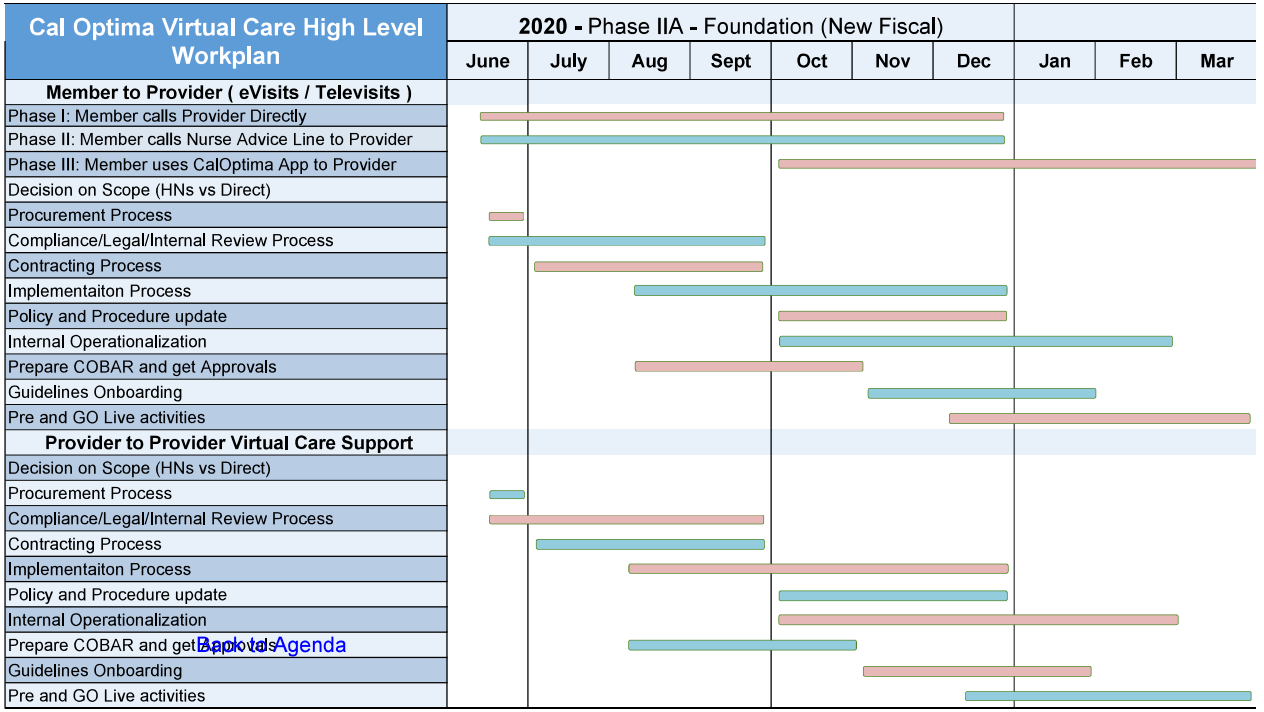

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TEAM SUMMARY SCORES

RFP 19-020 – Mobile Text Messaging Services

Proposals Scores

Vendor Name	Score
mPulse	3.57
HealthCrowd	3.45
Bluespire	3.63
TigerConnect	3.32
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

Interview Scores

Vendor Name	Score
mPulse	4.30
HealthCrowd	4.18
Bluespire	3.73
TigerConnect	2.51
Medecision	0.00
MTX Group Inc.	0.00
Variedy	0.00
Care3	0.00

Overall Scores

Vendor Name	Score
mPulse	3.94
HealthCrowd	3.81
Bluespire	3.68
TigerConnect	2.92
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

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M E M O R A N D U M

DATE:	May 22, 2019
TO:	Pshyra Jones, Ashley Young, Kelly Rex-Kimmet, Belinda Abeyta, Albert Cardenas, Erica Neal, Christine Sisil, Adriana Ramos, Edwin Poon, Diane Ramos, Lisa Ha
FROM:	Maria Medina, CPPB
SUBJECT:	RFP 19-020 – Mobile Text Messaging Services

EVALUATION PROCESS INSTRUCTIONS:

IMPORTANT….If you are contacted by any vendor regarding this RFP process, please do not speak with this vendor and forward all calls to my attention.

Step One: ***Review all Proposals***. Evaluation committee members were provided with copies of each RFP response to begin their individual review of the Proposals. **Take notes, make comments and/or prepare questions for discussion.** Do not score at this point.

Step Two: ***Determine status***. Make an initial determination as to whether each Proposal is "responsive" or "non-responsive." A "responsive" proposal conforms in all material respects to the RFP. A proposal may be deemed "non-responsive" if essential required information is not provided, the submitted price is found to be excessive or inadequate as measured by criteria stated in the RFP, or the proposal is clearly not within the scope of the project described and required in the RFP. *Extreme care should be used when making this decision because of the time and cost that a vendor has put into submitting a proposal. If a proposal is determined to be "non-responsive," it will not be considered further. The Purchasing department will make the final determination of responsiveness. If a determination of "non-responsiveness" is made, written justification must be provided for this conclusion.*

Step Three: ***Score proposals.*** Committee members should **INDIVIDUALLY** score the proposals based on the criteria established within the RFP. Please send me your individual scores by **12:00 Noon, June 5, 2019.** I will prepare a summary team score for all scorers.

Step Four: ***Evaluation Committee Meeting***. Once the proposals have been evaluated and scored by the individual committee members, the entire committee will meet to discuss the proposals and arrive at the final scoring. The committee should discuss all aspects of the proposals so that there is a "unified understanding" of the criteria and corresponding responses. Individual scores may be adjusted at this point based upon discussion. If any of the scores change I will prepare a new summary team rating. The highest score on the Summary Team score will be awarded the business.

Step Five: ***Discussion/Negotiation.*** This step is optional. If the committee is unsure of certain items or issues included in the RFP response, it may request further clarification from the vendor. The Purchasing department will distribute clarification questions to applicable vendor/s. Upon receipt of the vendor responses, the Purchasing department will distribute to the committee members.

Step Six: ***Best and Final Offer.*** This step is optional. A letter asking the vendors to submit a "Best and Final Offer" may be issued by the Purchasing department at the request of the evaluation committee. Once a "Best and Final Offer" is received, the committee will evaluate it in the same manner as the original Proposal.

Step Seven: ***Recommendation and Review.*** After the final scores from the above steps are tallied, the Purchasing department will contact the successful vendor and initiate the agreement process. Upon contract execution, the Purchasing department will notify the remaining vendors, informing them of our decision to award the business elsewhere.

PROPOSAL RATING INSTRUCTIONS:

The attached proposal evaluation form is to be used to initially rate and score proposals. Please enter your scores in the "raw score" fields of the Evaluation Score Sheet. *Please forward to my attention, an electronic version of your completed Evaluation Score Sheet no later than* ***12:00 Noon, June 5th****. The initial results will be presented at the meeting and will form the basis of our discussion.*

- EVALUATION CRITERIA

  Evaluation criteria and respective weights are as follows:

Evaluation Criteria	Raw Possible Points	Weight Factor	Total Possible Score
Letter of Transmittal Requirements, Proposal Organization, completeness of response	5	10%	0.50
Process: Vendor can perform all aspects of the Contract, knowledge of industry, proper qualifications, can handle our size and needs	5	25%	1.25
Related experience: Years, Worked with Vendors similar to CalOptima, References	5	20%	1.00
Account Team: Qualifications, Location, Experience	5	15%	0.75
Price	5	20%	1.00
Contract Changes (Purchasing Only)	5	10%	0.50

  With the four different evaluation criteria, there is a total of 30 "raw points" available for each Proposal. Each evaluation criteria has been weighted in proportion to its perceived value to the overall score.

  Each criterion should be rated separately from the others. In other words, if vendor "A" appears highly capable of effectively completing the project/providing the service, has very good qualifications and related experience, but in your opinion, does not have competitive rates, you should not downgrade your score for the first two criteria as punishment for not doing well on the other criteria categories. It is perfectly acceptable to give vendor "A", a higher score for the first two criteria, and a lower score on the other applicable criteria.

  The Evaluation Team will only need to input their scores in the rows entitled "raw score" of the attached electronic Evaluation Score Sheet.

- PROPOSAL CRITERIA RATINGS (0-5)

  Please rate each Proposal on a scale of 0-5 for each evaluation criteria. This scale and the meaning of the ratings are as follows:

  5 - Outstanding - far exceeds minimum requirements, offers prospects of extremely high-quality work product.

4 - Very Good - exceeds minimum requirements, offers prospects of very high work product.

3 - Good - meets minimum requirements, although there are deficiencies which may result in some flawed work products.

2 - Barely adequate - several deficiencies which may result in flawed work product.

1 - Deficient - does not meet requirements, poses virtual certainty of high risk of flawed products and generally inadequate performance.

0 - Totally non-responsive and noncompetitive to the RFP.

- SCORE (Maximum 5 points)

  Raw Possible Points Evaluation Rating x Weight/Factor = Total Possible Score
  The maximum weighted score for any given Proposal is 5 points.

Reminder….. The EVALUATION MEETING is scheduled for June 6th from 1:00pm – 2:00pm in conference room 802-S

I can be reached on ext. 8659 for any questions. Thank you.

Scope of Work

I. OBJECTIVE

CalOptima is seeking a CONTRACTOR to provide Mobile Text Messaging services to enhance member engagement. The successful Offeror must support CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.

The successful Offeror will provide technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.

II. MEMBERSHIP

CalOptima's membership is provided for reference only.

CalOptima Membership*

Program	Description	Members
Medi-Cal	California's Medicaid Program for low-income children, adults, seniors and people with disabilities	689,641
OneCare Connect	Medicare-Medicaid Plan for people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits, adding supplemental benefits for vision, transportation and dental services, and providing comprehensive care coordination	14,104
OneCare	Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal	1,417
PACE	Program of All-Inclusive Care for the Elderly for older adults, providing comprehensive health services through the CalOptima PACE center	394

**Membership Data as of January 31, 2020*

III. REQUIREMENTS

A. Comply with all state and federal regulations, including but not limited to FDA, Affordable Care Act (ACA), Centers for Medicare and Medicaid Services (CMS), the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **The Contractor shall be required to sign a Business Associate Agreement (BAA) prior to the commencement of the Contract.**

B. **MOBILE TEXT MESSAGING**

1. Text Campaign Strategy

   a. Successful Offeror's mobile text messaging services must be able to support specific initiatives to help increase member engagement and communications between CalOptima andthe member and. Please describe and/or provide any

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samples to demonstrate how the Successful Offeror can support the following with targeted texting strategies:

- Quality Improvement (i.e. preferable experience in assisting health plans with improving HEDIS measures, preventive care, medication adherence, wellness, disease management, etc.)
- Health Plan Navigation Support (i.e. providing information on health care benefits, how to access CalOptima's programs or services such as Nurse Advice Line, assisting new enrollees on how to choose a doctor, etc.)
- Surveys to measure member satisfaction with CalOptima's services

2. Text Messaging Features
   a. Please describe the messaging features that are supported by the Successful Offeror. At minimum, they should include:
      - Text blasting/bulk messaging
      - Two-way text messaging
      - Tailored or personalized text messages
      - Automated responses
      - Keywork responses
      - Conditional branch logic (allow for keyword and automated responses based on predefined algorithm)
      - Message scheduling/staggering
      - Message queuing
      - Active links
      - Voting and polling
      - Short codes
      - Unicode support

3. Content

   a. Content must be written at a sixth-grade reading level or below to ensure the information is easy to understand. Please provide any details related to content development, required approvals, and customization options.

4. Enrollment

   a. Successful Offeror shall have policies and proecuedres for managing the users opt-out/opt-in and text preferences.

   b. Successful Offeror must be able to support CalOptima with identifying mobile numbers and land line numbers to distinguish users who are able to receive text messages.

IV. DATA EXCHANGE, SECURITY, AND SYSTEM INTERFACE REQUIREMENTS

A. The Successful Offeror must have a Health Insurance Portability and Accountability Act (HIPAA) compliant platform and secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data. Please share the process, policies and/or procedures Successful Offeror will follow to ensure HIPAA regulations are met and certified as HIPAA compliant.

B. Successful Offeror shall have the ability to handle eligibility files and to download from CalOptima's FTP site. It shall also have the ability to take the eligibility files and set-up a system load.

C. Successful Offeror must ensure that all data is kept for ten (10) years at minimum.

D. Successful Offeror agrees, upon termination of the relationship (regardless of which party terminates), to provide all information required for successful transition files at no additional cost.

V. CULTURAL AND LINGUISTICS

A. CalOptima supports seven (7) "threshold" languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese, and Arabic. Successful Offeror shall have ability to support mobile text messaging services in English and Spanish, at minimum. Please list any other languages that are supported by the Sum.

VI. REPORTING

A. Successful Offeror's reporting mechanisms should be able to provide real-time updates of text message delivery and campaign performance. Describe what information is captured on these reports.

B. Summary reports shall be provided at the conclusion of each text campaign that measures performance and outcomes. Describe the report features and the data elements that are captured.

C. Reports should be in a format that allows data to be integrated into CalOptima systems. How will data be shared with CalOptima (i.e. web portal, secure email, FTP transfer, etc)?

D. Does the Offeror include any analysis in the standard reporting package?

E. All offerors shall provide a sample copy of the reports with its proposals.

VII. SERVICE LEVEL AGREEMENT (SLA)

What Service Level Agreements and warranties does your company provide? Please provide detail levels and metrics. Include a specific time element offered.

VIII. IMPLEMENTATION SCHEDULE

Offeror shall provide an implementation timeline, including benchmarks and milestones as part of its response.

IX. PRICING MODEL

Offeror shall provide pricing model/structure for implementation, services provided and any other fees CalOptima may incur.

TEXTING PROGRAM & CAMPAIGN

SUBMISSION FORM

INSTRUCTIONS:
This form is required for all Medi-Cal managed care plans' (MCP) texting program and/or its individual texting campaign(s). Complete this form, including the Indemnification Agreement and email it to your DHCS Contract Manager for approval. DHCS will review and respond within 60 days of submission of the form.

Email subject line must include "For your approval: MCP name, Subplan name if applicable, Texting, and Campaign(s). For example:

- For a campaign submission: "For your approval: PlanA_Texting_New Member Orientation"
- For multiple campaigns submission: "For your approval: PlanA_Texting_Multiple Campaigns"

MCP is required to complete **all sections (Sections A-C)** when MCP first seeks an approval for a new Texting Program. Once MCP's new texting program has been approved and MCP would like to add additional campaigns, MCP will need to complete **Section A** and **Section C** only.

MCP can replicate **Section C** for additional campaigns if MCP desires to submit multiple campaigns for approval at the same time.

As a condition of approval for any text messaging campaign, a designee within the MCP who holds signatory authority is required to execute the attached Indemnification Agreement. Approval of the campaign is not considered final until the MCP receives a signed copy of the Indemnification Agreement back from the DHCS.

Key definitions

1. Texting Program: MCP's overall program design and infrastructure utilized to implement individual text messaging campaigns.
2. Texting Campaign: MCP's specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).

SECTION A: GENERAL INFORMATION

1. Managed Care Plan: _____ Date: _____
2. Submitted on behalf of a subcontracting MCP: _____ ☐ N/A
3. List the county or counties where you conduct your texting campaign(s):

   _____

SECTION B: TEXTING PROGRAM POLICY & PROCEDURE

1. Does the MCPs policy describe the process the MCP will use to obtain Members' Agreement to Participate (i.e., release of information) either through active opt-in or assumed opt-in approach and explain how a member can opt-out and the timeline associated with processing such requests? Please attach MCP's program policy and procedure (PnP) and process workflow. If no, please describe.

   ☐ Yes

   ☐ No

2. Does MCP's policy describe any financial costs that MCP's Members may incur from receiving the Agreement to Participate message(s) and any potential costs of future messages? If no, please describe.

   ☐ Yes

   ☐ No

3. Is the MCPs proposal related to redetermination outreach?

   ☐ Yes

   ☐ No

If yes, does the MCPs policy indicate outreach will only be made to members who are on the MCPs monthly 834 file showing an HCP status of 05?

☐ Yes

☐ No

4. Has the MCP provided texting script(s) to obtain MCP's Members' Agreement to Participate, or texting script(s) to allow MCP's members to opt-out?

☐ Yes

☐ No

5. Are the texting script(s) provided to members at the sixth grade reading level, per Exhibit A, Attachment 13, 4(C) of the contract with DHCS?

☐ Yes

☐ No

6. Does the texting script have any health education information? If yes, has the campaign script been reviewed and approved by the MCP health educator in accordance with APL 18-016?

☐ Yes

☐ No

7. Does the MCPs policy describe how the MCP considers privacy concerns and custody/guardianship situations based upon information available to MCP? If no, please describe.

☐ Yes

☐ No

8. Does the MCPs policy describe how the MCP protects Members' PII and/or PHI and meet requirements of Exhibit G of the contract with DHCS? If no, please describe.

☐ Yes

☐ No

9. Is the MCP using a third-party vendor? If yes, who is the vendor? If MCP has not already sent the vendor's Master Service Agreement and all contract amendments to DHCS, attach them to this application.

☐ Yes

☐ No

10. Does the vendor's Master Service Agreement comply with all applicable state and federal law and contract requirements in particular, Exhibit G of the contract with DHCS?

☐ Yes

☐ No

SECTION C: [SPECIFIC TEXTING CAMPAIGN NAME]

1. What is the overall purpose of campaign? Circle one.
   a. Providing health education information
   b. Providing written member information
   c. Reminding of preventive care visits
   d. Supporting statewide regulatory efforts on digital communications
   e. Other(s): _____

   Disclaimers: MCP certifies that any health education information provided through the campaign has been reviewed and approved by the MCP health educator in accordance with APL 18-016.

   Information on eligibility redetermination cannot be included in text campaign.

2. Describe the objectives of the campaign.

3. Does the campaign include any member incentives?

   ☐ Yes

   ☐ No

   If yes, has the incentive been reviewed and approved by DHCS health educators in accordance with APL 16-005?

   ☐ Yes

   ☐ No

4. Does the campaign include Personal Identification Information (PII) and/or Protected Health Information (PHI)? If yes, confirm the answer to question 7 in Section B above is checked "yes."

   ☐ Yes

   ☐ No

5. Who is the campaign's target population?

6. Who will be excluded from the campaign based upon information available to MCP (e.g., Members with SUDS, HIV/AIDS, behavioral health, minors in family planning, etc.)?

7. Does MCP require additional Members' Agreement to Participate for this specific texting campaign (i.e., extra opt-in requirement for sensitive services or PHI/PII content)?

   ☐ Yes

   ☐ No

8. What is the campaign length? When will it start and end?

9. What is the frequency of text messaging?

10. In what language(s) will the campaign be available? Will members have an option to receive text messages in their primary language (i.e. Spanish)?

11. Provide content script of the campaign.

12. What is the expected outcome of the campaign?

Attestations:

☐ For new campaign submission only (Section C), MCP attests that the Texting Program submission (Section B) that was previously approved contains no changes. Each new campaign will require an executed Indemnification Agreement.

☐ For ongoing texting programs, MCP will report to the DHCS Contract Manager the outcomes of plan texting campaigns on an annual basis, 45 days from the annual anniversary of the campaigns initiation. For time-limited campaigns, MCP will report outcomes six months after a program ends.

FOR DHCS USE ONLY (OR USE ALTERNATE DHCS AIR FORM)

1. DHCS Reviewer's Name: _____ Date: _____
2. DHCS Reviewer's Title: _____
3. DHCS Reviewer's Decision:

☐ Approved as submitted

☐ Approved with the following changes:

_____

☐ Denied

Reason (s): _____

_____

☐ Request for more information: _____

_____

_____

TEXT MESSAGING CAMPAIGN INDEMNIFICATION AGREEMENT

In consideration of the Department of Health Care Services' approval of [INSERT HEALTH PLAN NAME's] text messaging program, [INSERT HEALTH PLAN NAME] agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected beneficiaries and any other costs associated with any actual or alleged breach of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 and the Information Practices Act, California Civil Code section 1798 et seq. by [INSERT HEALTH PLAN NAME] and any vendor, contractor, subcontractor that [INSERT HEALTH PLAN NAME] contracts with for the approved text messaging campaign.

_____	_____
Health Plan Representative	DHCS Contract Manager
_____	_____
Date	Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 16, 2020
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

4. Consider Recommending Board of Directors' Approval of the Calendar Year 2021 Behavioral Health Applied Behavior Analysis Pay for Value Performance Program

Contacts

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, R.N., Executive Director, Quality and Population Health Management, (714) 246-8400
Edwin Poon, Ph.D., Director, Behavioral Health Services, (Integration) (714) 246-8400

Recommended Action

Recommend that the Board of Directors approve the Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program for the Measurement Period effective January 1, 2021 through December 31, 2021.

Background

Behavioral Health Treatment (BHT) is a Medi-Cal covered service under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for members under 21 years of age. From 2014 to 2017, CalOptima Medi-Cal Behavioral Health (BH) benefits, including BHT services, were delegated to a Managed Behavioral Health Organization (MBHO). In 2018, CalOptima integrated Medi-Cal BH benefits within CalOptima internal operations. Currently, approximately 3,000 CalOptima Medi-Cal members receive BHT services each year.

Applied Behavior Analysis (ABA) is a type of BHT service. It has been identified as an evidenced-based approach for preventing or minimizing the adverse effects of behaviors that interfere with learning and social interaction. ABA therapy is intense, with treatment hours averaging 9 to 10 per week. The course of treatment can last for several years or longer. Most of the direct services are rendered by paraprofessionals who are unlicensed and require ongoing supervision. The education requirements for paraprofessionals are high school diploma, a minimum of 40 hours of training, and a demonstrated competency in implementing ABA intervention.

Since the Department of Health Care Services (DHCS) implemented the BHT benefit in 2014, CalOptima has followed the State Plan Amendment (SPA 14-026) regarding the types of providers allowed to supervise paraprofessionals:

1. Board Certified Behavior Analyst (BCBA)
2. Behavior Management Consultant (BMC)
3. Behavior Management Assistant (BMA)
4. Board Certified Assistant Behavior Analyst (BCaBA)

BCBA and BMC are considered the top tier supervisor types, while BMA and BCaBA fall under the mid-tier level. When a paraprofessional is supervised by a mid-tier provider, a BCBA or BMC is still required to oversee the work to ensure quality of care.

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In 2018, CalOptima proposed to phase out the mid-tier level (BMAs and BCaBAs) within a one-year period. The rationale for phasing out mid-tier was to raise the overall quality of care and align our approach with most commercial insurance plans and the Regional Center of Orange County. At that time, ABA providers expressed concerns over lack of available BCBAs and the associated cost. As a result, CalOptima has continued to maintain the 3-Tier model approach. Currently, approximately 50% of supervisions are conducted by the mid-tier level supervisors.

During the 2019 DHCS medical audit, file review showed some ABA providers were not providing the hours as stated in individual members' treatment plans. DHCS noted that when ABA providers insufficiently deliver direct service hours, members may not receive effective treatment and consequently, the quality of care may be compromised. DHCS recommended that CalOptima update and implement policies and procedures to monitor and ensure that ABA providers are providing BHT services based upon approved treatment plans, including providing direct service hours as authorized. Since then, CalOptima has developed a monitoring tool to track utilization of ABA direct services. Data reports show that the recommended hours authorized are not being fully utilized. Currently, on average, approximately 41% of authorized hours are being utilized. The DHCS medical audit findings also support the assumption that utilizing only top-tier level for supervision and monitoring of the ABA providers will help promote member and family-centered treatment planning, ensure appropriate utilization of direct service hours, and improve member experience with the ABA services. Currently there are no HEDIS or standardized measures for the quality of BHI ABA services

Discussion

In an effort to improve the quality of ABA services, CalOptima staff proposes to implement a Pay for Value (P4V) program designed to address the quality issues mentioned above. CalOptima has had good success with P4V programs targeting medical care both at the Health Network (HN) and individual provider levels. With CalOptima directly managing BH Services, there is an opportunity to leverage the same P4V program success to improve ABA services.

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that strengthens CalOptima's mission of providing members with access to quality health care. Annually, CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis includes evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, staff analyzes the difficulty of improving a measure due to the size of the eligible population or difficulty in data gathering. Finally, staff evaluates any changes to the specifications of the measures that are important to CalOptima's NCQA Accreditation status and/or overall Health Plan Rating.

The purpose of CalOptima's P4V program for the Health Networks, including the CalOptima Community Network (CCN), is consistent with the P4V programs of the previous years, which remains:

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1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

With CalOptima directly managing BH services, there is an opportunity to leverage the same P4V program success to improve ABA services.

The BHI ABA P4V Program is designed to improve quality of care, result in better individualized treatment recommendations, consistent treatment delivery, and decrease member grievances. Since there are currently no HEDIS or standardized measures for the quality of BHI ABA services, staff recommends that the program focus on two measurable objectives associated with quality of care:

1. Increase in the percentage of BCBAs supervising ABA services.
2. Increase in the percentage of authorized hours that members receive.

The baseline period will be January 1, 2020 to December 31, 2020 and the measurement period will be January 1, 2021 to December 31, 2021, with providers to be paid within 90 days of the close of the measurement year, by the end of March 2022. To earn the incentive, ABA providers will need to reach the target goals for each measure, which are set at four levels. The incentive will be calculated based on the level they reach, with a corresponding percent of annual claim paid amount. The maximum combined incentive will be no more than 4% of the provider's annual claims payment. Each ABA provider will receive a monthly report during the measurement year to evaluate their progress. Below are the specifications of the two proposed measures:

Measure 1

$$\%\text{ of supervision hours completed by BCBA/BMC} = \frac{\text{Total H0032* HO** hours per month}}{\text{Total H0032 per month}}$$

* H0032 is the CPT code for supervision
** HO is the modifier code for BCBA

Incentive Level	1	2	3	4
Measure Target Goal	50.00%	65.00%	80.00%	95.00%
Incentive by annual claims paid	0.50%	1.00%	1.50%	2.00%

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Measure 2

% of authorized 1:1 hours provided = $\frac{\text{Total number of 1:1 claims paid}}{\text{Total number of authorized 1:1 hours}}$

Incentive Level	1	2	3	4
Measure Target Goal	See Table below			
Incentive by annual claims paid	0.50%	1.00%	1.50%	2.00%

			1	2	3	4
Baseline rate			**Target Goal**			
70%	and	up	72.50%	75.00%	77.50%	80.00%
65%	to	69%	68.75%	72.50%	76.25%	80.00%
60%	to	64%	65.00%	70.00%	75.00%	80.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%
50%	to	54%	57.50%	65.00%	72.50%	80.00%
45%	to	49%	53.75%	62.50%	71.25%	80.00%
40%	to	44%	50.00%	60.00%	70.00%	80.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%

Incentive Payout Examples:

Provider A: Achieves Measure 1 and 2 target goals

	Measure 1	Measure 2
Y2020 Baseline Rate	40%	38%
Y2021 Measurement Rate	50%	46.25%
Incentive by Annual Claims Paid	**0.50%** (Level 1)	**0.50%** (Level 1)

Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022

Provider B: Achieves only one target goal

	Measure 1	Measure 2
Y2020 Baseline Rate	30%	60%
Y2021 Measurement Rate	48%	72%
Incentive by Annual Claims Paid	0% (did not meet target minimum)	**1.00%** (Level 2)

Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022

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Fiscal Impact

The recommended action to approve the Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program is a budgeted item under the Board-approved Fiscal Year 2020-21 Operating Budget and is estimated not to exceed $600k for the six months of January through June 2021. Management will include expenses related to the remainder of the measurement period in future operating budgets.

Rationale for Recommendation

Based on two measurable performance metrics, the proposed behavioral health P4V program is intended to improve quality by incentivizing applied behavioral analysis (ABA) providers to increase BCBA/BMC supervision of the delivery of ABA services and move toward a two tier supervision model, and ensure that members receive the appropriate number of necessary and authorized ABA hours.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. ABA P4V Presentation 9/16/2020

/s/ Richard Sanchez *09/09/2020*
Authorized Signature **Date**

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A Public Agency

CalOptima

Better. Together.

Behavioral Health Applied Behavior Analysis Pay for Value Performance Program

Quality Assurance Committee Meeting

September 16, 2020

Edwin Poon, Ph.D., Director, Behavioral Health Integration

Donald Sharps, M.D., Medical Director, Behavioral Health Integration

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Agenda

- Activities and Timeline
- Background
- Discussion
- Proposed Performance Measures and Rationale
- Framework and Fiscal Impact
- Oversight and Stakeholder Engagement

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CalOptima
A Public Agency

Activities and Timeline

- Finance Review — Completed May 26
- P4V Steering Group — Completed June 29
- Executive Staff Meeting — Completed July 14
- Stakeholder Meeting — Completed August 7
- QIC Meeting — August 11
- QAC Meeting — September 16
- BOD Meeting — October 1

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CalOptima
A Public Agency

Background

- Behavioral Health Treatment (BHT) includes Applied Behavior Analysis (ABA).
  - Under 21 years of age
  - 2014 — Only if diagnosed with Autism Spectrum Disorder (ASD)
  - 2017 — Included non-ASD (typically intellectual disability)
- Board Certified Behavioral Analyst (BCBA) conducts Functional Behavioral Assessment (FBA) and develops treatment plan.
- Paraprofessionals conduct in-home training and behavior intervention services.
- ABA service is an intensive and long-term therapy.
- Service is renewed every six months.

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CalOptima
A Public Agency

Discussion: Supervision

- Follows the State Plan Amendment (SPA 14-026)
- Types of supervisors:
  - Board Certified Behavior Analyst (BCBA)
  - Behavior Management Consultant (BMC)
  - Behavior Management Assistant (BMA)
  - Board Certified Assistant Behavior Analyst (BCaBA)
- Supervision Models: 2-Tier vs. 3-Tier
  - 9 of 10 Medi-Cal managed care plans allow 3-tier
  - Three of six commercial plans allow 3-tier

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CalOptima
A Public Agency

Discussion: Supervision (cont.)

- Initially proposed 100% supervision by BCBA or BMC (2-Tier Model)
  - CalOptima accepted 3-Tier Model, if BCBA supervises all cases

2-Tier	3-Tier
BCBA or BMC	BCBA or BMC
Paraprofessional	BMA or BCaBA (mid-tier)
	Paraprofessional

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CalOptima
A Public Agency

Discussion: Under Utilization

- ABA Utilization vs. Authorization

All ABA Providers

Authorization Start Date : 2019-06 to 2019-11
Claim Date of Service : 01/01/2018 and onwards

Diagnosis	ABA Code Category	Procedure Code	Modifier	Avg. Auth Units Requested	Avg. Auth Units Authorized	Avg. Auth Units Utilized	% of Units Utlilized
non-ASD Dx	One-on-One	H2019		561	561	242	43%
			HM	672	672	0	0%
			HO	957	957	826	86%
ASD Dx	One-on-One	H2019		684	684	373	54%
			HM	1,207	1,207	234	19%
			HO	877	877	394	45%
Average Total				826	826	345	41%

ABA Code Category
- [ ] FBA
- [x] One-on-One
- [ ] Parent Consultation
- [ ] Social Skills
- [ ] Supervision

Diagnosis
- [x] ASD Dx
- [x] non-ASD Dx

FROM_Auth Start Date (... 2019-06

TO_Auth Start Date (all ... 2019-11

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Proposed Performance Measures

- **Metrics**
  - **% of supervision hours completed by BCBAs/BMCs**
  - **% of 1:1 hours provided vs recommended**
- We want to make sure the highest quality of supervision is being provided.
- Data show intervention recommendations and what is delivered are not equivalent.

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Rationale for Recommendation

- Metric #1: To increase percentage of BCBAs/BMCs supervising cases
  - ABA providers do use 100% BCBAs for other commercial plans that require this.
  - They may increase number of BCBAs supervising CalOptima cases with incentive.
  - Improve quality, decrease impairments and comply with state plan amendment (SPA).

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Rationale for Recommendation (cont.)

- Metric #2: To increase percentage of hours utilized vs authorized
  - ABA providers may increase/maintain paraprofessional staffing as this has been reason given for not utilizing hours authorized.
  - They may more individualize the treatment recommendations rather than literature-based numbers.

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ABA P4V Framework

- 81 contracted ABA providers*
- Framework: 4 Tier of Payout
- Measurement year: CY2021
- Payout: Q1 2022

Projected Percent of ABA Cases per Tier

Tier	% of Cases	Payout by Tier	Total Payout
Tier 1	40%	1%	0.4%
Tier 2	30%	2%	0.6%
Tier 3	20%	3%	0.6%
Tier 4	10%	4%	0.4%
TOTAL			**2.0%**

*Exception Kaiser

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ABA P4V Framework (cont.)

- Metric #1: % of supervision hours completed by BCBA/BMC

Annual Percentage P4V

0.5%	1.0%	1.5%	2.0%
Goal rate for P4V			
50.00%	65.00%	80.00%	95.00%

- Metric #2: % of 1:1 hours provided vs. recommended

Annual Percentage P4V

Base rate			0.5%	1.0%	1.5%	2.0%	Increase to reach next level
			Goal rate for P4V				
70%	and	up	72.50%	75.00%	77.50%	80.00%	2.50%
65%	to	69%	68.75%	72.50%	76.25%	80.00%	3.75%
60%	to	64%	65.00%	70.00%	75.00%	80.00%	5.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%	6.25%
50%	to	54%	57.50%	65.00%	72.50%	80.00%	7.50%
45%	to	49%	53.75%	62.50%	71.25%	80.00%	8.75%
40%	to	44%	50.00%	60.00%	70.00%	80.00%	10.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%	11.25%

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ABA P4V Incentive Payout — Example

- Provider A — Achieves Measures 1 and 2 target goals

	Measure 1	Measure 2
Y2020 Baseline Rate	40%	38%
Y2021 Measurement Rate	50%	46.25%
Incentive by Annual Claims Paid	0.50% (Level 1)	0.50% (Level 1)
Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022		

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ABA P4V Incentive Payout — Example (cont.)

- Provider B — Achieves only one target goal

	Measure 1	Measure 2
Y2020 Baseline Rate	30%	60%
Y2021 Measurement Rate	48%	72%
Incentive by Annual Claims Paid	0% (did not meet target minimum)	1.00% (Level ~~1~~2)
Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022		

Rev. 9/16/2020

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Preliminary Fiscal Impact

MAX	4.0%
Projected Payout (of 4%)	50.0%
Annual ABA Spend (~)	$48,000,000
Annual P4V Spend	$960,000
FY21 (6-months Jan–Jun ’21)	**$480,000**

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Oversight and Stakeholder Engagement

- Oversight:
  - ABA P4V performance monitoring will fall under the same structure currently designed for Pay for Value
    - Generated Prospective Rate Reports (Dashboard)
    - Providers will be able to track their progress on each Pay for Value measure during performance measuring period.
  - Next steps
    - Determine delivery method and frequency
    - Support for provider inquiries
- Stakeholder Engagement:
  - August 7 — ABA Council
    - Feedback received
  - Q4 ABA Council — TBD

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Our Mission

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

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Better. Together.

Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Results (MY 2019 Performance)

Quality Assurance Committee
September 16, 2020

Kelly Rex-Kimmet, Director, Quality Analytics

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What Is HEDIS?

- The Healthcare Effectiveness Data and Information Set (HEDIS) is a performance measurement tool used by health plans to reliably compare how they perform on important dimensions of care and service.
- HEDIS makes it possible to compare performance on an “apples-to-apples” basis to national benchmarks in more than 96 measures across six domains of care.
- The measurement year for HEDIS is the prior calendar year performance. These results reflect performance in calendar year 2019.
- All HEDIS results are independently audited annually.
- Results are calculated and reported annually.

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HEDIS and Regulatory Requirements

- Department of Health Care Services (DHCS)
  - Managed Care Accountability Set (MCAS) – 1st year new measure set
  - Select measures must achieve new minimum performance level (MPL) - Increased from national Medicaid 25th percentile to 50th percentile
- Centers for Medicare & Medicaid Services (CMS)
  - Medicare/SNP and MMP Rates and Patient Level Data: Not required this year due to COVID-19
  - CMS 2021 Star Rating: Using HEDIS 2019 results

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HEDIS and Regulatory Requirements (cont.)

- National Committee for Quality Assurance (NCQA)
  - Accreditation scores: HEDIS 37 points and CAHPS 13 points
    - Estimated CalOptima will keep Commendable status
  - NCQA Health Plan Ratings- not released for 2020-2021 due to COVID-19
  - Quality Compass Benchmarks-submit for all LOB

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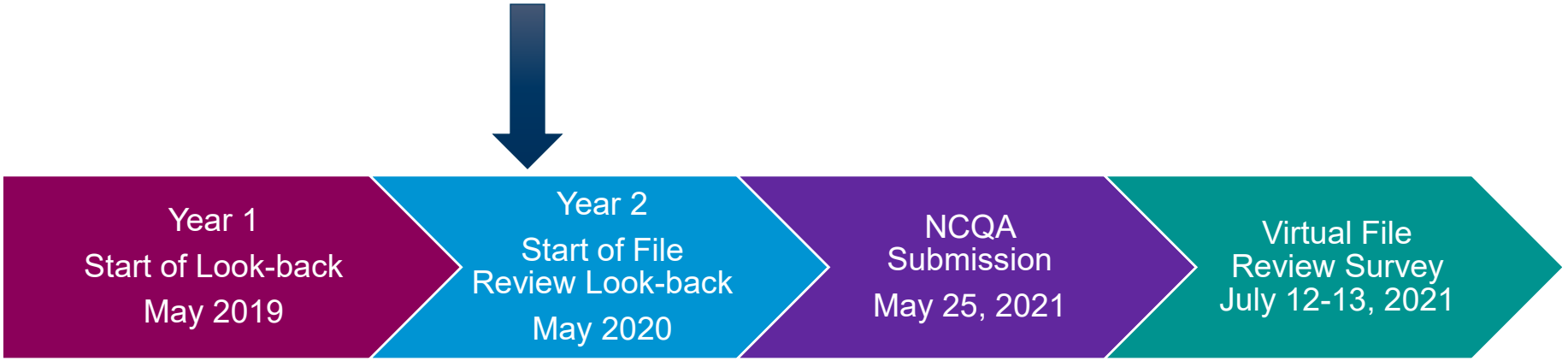
NCQA Accreditation Timeline & Milestones

July 2020
10 Months Remain



File Review Look-Back:

UM/CCM/Appeals: May 2020–May 2021

Credentialing: May 2018 – May 2021

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HEDIS Scope — Reporting

- 6 submissions (IDSS) to NCQA /DHCS
  - Separate submissions for each lines of business (LOB): 3
  - Separate DHCS, SNP and MMP submissions: 3
- 1 Patient Level Detail (PLD) file submitted to DHCS
  - 4 PLD files for CMS are waived this year

- Plan results for all product lines audited by NCQA Certified HEDIS auditors.
- **All measures passed audit and are fully reportable**

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HEDIS Scope — Reporting (cont.)

- COVID-19 Impacts
  - NCQA and DHCS allows to “rotate” the hybrid measures reported rate (use last year’s result) due to COVID-19 impact on chart reviews
  - Next year HEDIS results (MY2020)
    - Telehealth (impact is not clear currently): Telehealth expanded to more measures
    - May be negatively impacted due to COVID-19

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HEDIS Scope — Medical Records Review

- Medical records data collection challenge due to COVID-19
  - Guidance from DHCS and CMS to reduce burden from provider offices for medical records collection
  - Provider offices closed or restricted on-site medical records retrieval
  - The capacity of handling medical records reduced in provider offices
  - The production of copy service reduced due to safety concerns and staff reductions

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HEDIS Scope — Medical Records Review (cont.)

- 56 measures/sub-measures required medical record review with 9,462 chart chases
  - Medi-Cal: 20 measures with 4,340 chart chases. 97.1% retrieval rate
  - OneCare: 18 measures with 2,099 chart chases 95.6% retrieval rate
  - OneCare Connect: 18 measures with 3,023 chart chases. 97.3% retrieval rate
  - Excellent retrieval rates despite COVID-19!

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Summary Results: Medi-Cal

- **All DHCS MPLs have been met !!**
  - Measures that demonstrated (statistically) significant improvement:
    - Well-Child Visits in the First 15 Months of Life (W15)
    - Prenatal and Postpartum Care (break in trending from PY)
    - Prenatal Immunization Status
    - Statin Therapy for Patients with Diabetes (SPD)
    - Use of Opioids From Multiple Providers (UOP)
    - Adult's Access to Preventive/Ambulatory Services (AAP)
    - Adult Immunization Status
  - Measures statistically significantly lower
    - Asthma Medication Ratio >50% (50th percentile this year)
    - Follow-up Care for Children Prescribed ADHD Medication (ADD)
    - Lead Screening in Children (75th percentile this year)

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Summary Results: Medi-Cal (cont.)

Opportunities: Behavioral Health and Access to Primary Care

- Behavioral Health:
  - ADHD Treatment dropped below 50th percentile
  - Follow-up After Emergency Room Visit for Mental Illness: Remains below 50th percentile but showed significant improvement compared to prior year
- Access to Primary Care
  - Telehealth has been adopted in many provider offices
  - CalOptima has also adopted a virtual care strategy

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Summary Results: Medicare

OneCare

- No measures are significantly changed
- Opportunities
  - Colorectal Cancer Screening (COL)
  - Care for Older Adults (COA)
  - Readmissions (PCR)

OneCare Connect

- Several measures demonstrated significant improvement
  - Statin Therapy for Patients with Diabetes (SPD)
  - Statin Therapy for Patients with Cardiovascular Disease (SPC)
  - Antidepressant Medications Management (AMM)
  - Plan All-Cause readmissions (PCR)
- Opportunities
  - Statin Therapy for Patients with Cardiovascular Disease (SPC)
  - Care for Older Adults (COA)
  - Readmissions (PCR)

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NCQA Percentiles and CMS Star Achievement

LOB	Measurement Year	Number of Measures at NCQA National Medicaid/Medicare Percentiles										Total # of measures*	Percent of measures at National 50th percentile/3 Star level or higher
		90th Percentile or 5-Star		75th Percentile or 4-Star		50th Percentile or 3-Star		25th Percentile or 2-star		<=10th Percentile or 1-Star			
		# 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	2019	9	14%	18	29%	16	25%	14	22%	6	10%	63	68%
	2018	9	14%	14	22%	17	27%	13	21%	10	16%	63	63%
	2017	10	17%	15	25%	10	17%	11	19%	13	22%	59	59%
OneCare	2019	1	3%	4	13%	9	28%	15	47%	3	9%	32	44%
	2018	0	0%	8	25%	9	28%	9	28%	6	19%	32	53%
	2017	0	0%	8	28%	11	38%	4	14%	6	21%	29	66%
OneCare Connect	2019	3	6%	5	10%	19	39%	10	20%	12	24%	49	55%
	2018	1	2%	6	12%	10	20%	14	29%	18	37%	49	35%
	2017	2	4%	5	11%	10	22%	9	20%	20	43%	46	37%

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

Notes: Benchmarks are based on Quality Compass 2019. Percentiles may change due to benchmarks changing over time. CMS Star Cut Points are based on Medicare 2020 Part C & D Star Ratings Technical Notes updated on 10/1/2019

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MY2019 Medi-Cal Measures Results

	Quality Compass MY2018 Percentiles Met	
	HEDIS MY2018	HEDIS MY2019
Weight Assessment and Counseling for Children/Adolescents (Physical Activity)	90th	90th
Immunization for Adolescents (combo 2)	90th	90th
Chlamydia Screening in Women	90th	90th
Controlling High-Blood Pressure	75th	**90th**
Statin Therapy for Patients with Cardiovascular Disease – Therapy	75th	**90th**
Diabetes Monitoring for People with Diabetes and Schizophrenia	75th	**90th**
Flu Vaccinations for Adults Ages 18–64	75th	**90th**
Timeliness of Prenatal Care	50th	**90th**
Postpartum Care	50th	**90th**

*Green=higher than last year; Red=lower than last year; +C=trend with caution due to specifications changes per NCQA Highlighted yellow = Break in trending

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MY2019 Medi-Cal Measures Results

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Weight Assessment and Counseling for Children/Adolescents (BMI)	50th	**75th**
Weight Assessment and Counseling for Children/Adolescents (Nutrition)	75th	75th
Cervical Cancer Screening **+C**	50th	**75th**
Comprehensive Diabetes Care (Eye Exam)	50th	**75th**
Statin Therapy for Patients with Diabetes (adherence) **+C**	75th	75th
Antidepressant Medications Management (Acute Phase Treatment)	75th	75th
Antidepressant Medications Management (Continuation Phase Treatment)	75th	75th
Use of Opioids From Multiple Providers (multiple Prescribers)	50th	**75th**
Use of Opioids From Multiple Providers (multiple Pharmacies)	50th	**75th**
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	75th	75th

*Green=higher than last year; Red=lower than last year; +C=trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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MY2019 Medi-Cal Measures Results

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Adult BMI Assessment	90th	**75th**
Lead Screening in Children	90th	**75th**
Statin Therapy for Patients with Cardiovascular Disease (Adherence) **+C**	90th	**75th**
Comprehensive Diabetes Care (HbA1c Poor Control)	90th	**75th**
Comprehensive Diabetes Care (HbA1c <8%)	90th	**75th**
Comprehensive Diabetes Care (BP Controlled)	75th	75th
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	90th	**75th**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	75th	75th

*Green=higher than last year; Red=lower than last year; +C=trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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MY2019 Medi-Cal Measures Results

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Well-Child Visits in the First 15 Months of Life (6+ visits)	**<10th**	**50th**
Medication Management for People with Asthma (5–64 year) – 75%	50th	50th
Persistence of Beta Blocker Treatment after a Heart Attack	25th	**50th**
Statin Therapy for Patients with Cardiovascular Disease (Therapy)	25th	**50th**
Non-Recommended CCS in Adolescent Females	25th	**50th**
Avoidance of Antibiotic Treatment for Acute Bronchitis	<10th	**50th**
Use of Imaging Studies for Low Back Pain	25th	**50th**
Use of Opioids From Multiple Providers (multiple Prescribers and Pharmacies)	50th	**50th**
Adolescent Well-Care Visits	50th	50th
Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years) **+C**	25th	**50th**
Children and Adolescents' Access to Primary Care Practitioners (7–11 years) **+C**	50th	50th

*Green=higher than last year; Red=lower than last year; +C=trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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MY2019 Medi-Cal Measures Results

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Childhood Immunization Status (comb10)	75th	**50th**
Breast Cancer Screening	50th	50th
Asthma Medication Ratio (5–64 years)	75th	**50th**
Comprehensive Diabetes Care (Medical Attention for Nephropathy)	50th	50th
Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia (SMC)	75th	**50th**

*Green=higher than last year; Red=lower than last year; +C=trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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MY2019 Medi-Cal Measures Results

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Pharmacotherapy management of COPD exacerbations (Corticosteroid)	25th	25th
Pharmacotherapy management of COPD exacerbations (Bronchodilator)	25th	25th
Follow-up After ED visit for Mental Illness (30–day)	<=10th	**25th**
Follow-up After ED visit for Mental Illness (7–day)	<=10th	**25th**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications (SSD)	25th	25th
Adults' Access to Preventive/Ambulatory Health Services (65+)	25th	25th
Children and Adolescents' Access to Primary Care Practitioners (12–24months) **+C**	25th	25th
Children and Adolescents' Access to Primary Care Practitioners (12–19 years) **+C**	25th	25th
Comprehensive Diabetes Care (HbA1c Testing)	50th	**25th**
Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase)	50th	**25th**
Follow-up Care for Children Prescribed ADHD Medication (Continuation Phase)	25th	25th
Appropriate Treatment for URI	50th	**25th**
Use of Opioids at High Dosage	50th	**25th**

*Green=higher than last year; Red=lower than last year; +C=trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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MY 2019 Medi-Cal Measures Results

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	<=10th	<=10th
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	<=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
Appropriate Testing for Pharyngitis (CWP)	<=10th	<=10th

*Green=higher than last year; Red=lower than last year; +C=trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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Three Year Trended Medi-Cal Measure Results MY 2017–2019

Benchmarks: NCQA National Medicaid MY 2018 Percentiles

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Pediatric Prevention Measures

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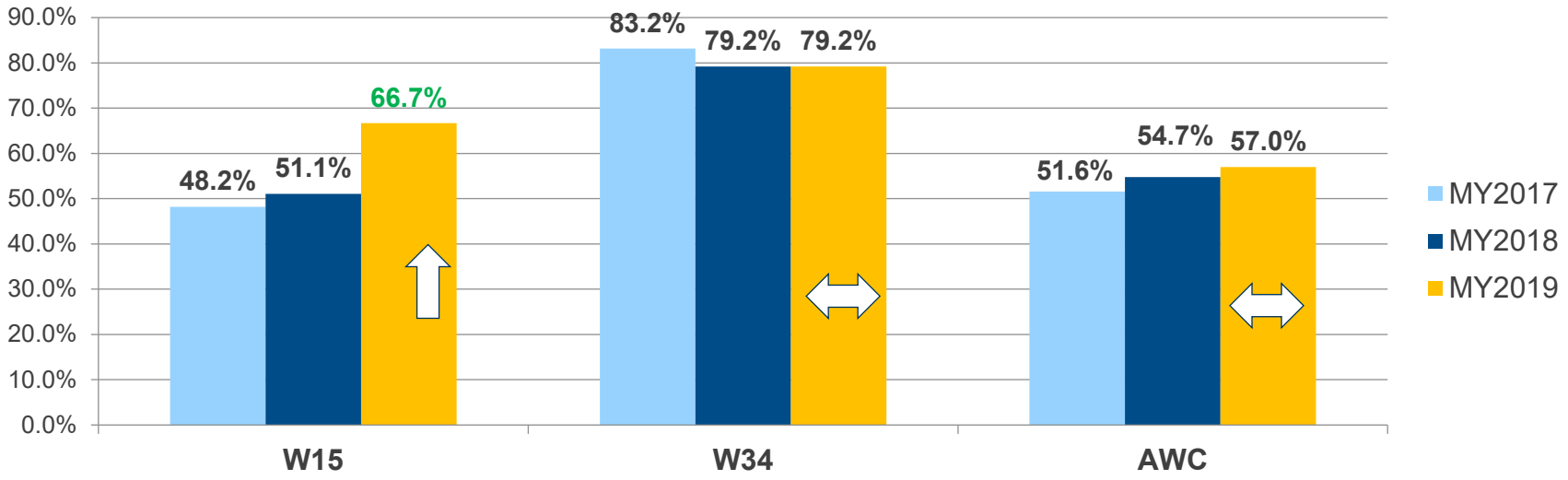
HEDIS 2020 Results: Medi-Cal Well Child Visits



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Well-Child Visits in the First 15 Months of Life - Six Well Child Visits (W15)	65.83%	69.83%	73.24%	65.83%	MPL, P4V
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	72.87%	78.46%	83.85%	81.16%	MPL, P4V
Adolescent Well-Care Visits (AWC)	54.26%	62.77%	68.14%	60.34%	MPL, P4V

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

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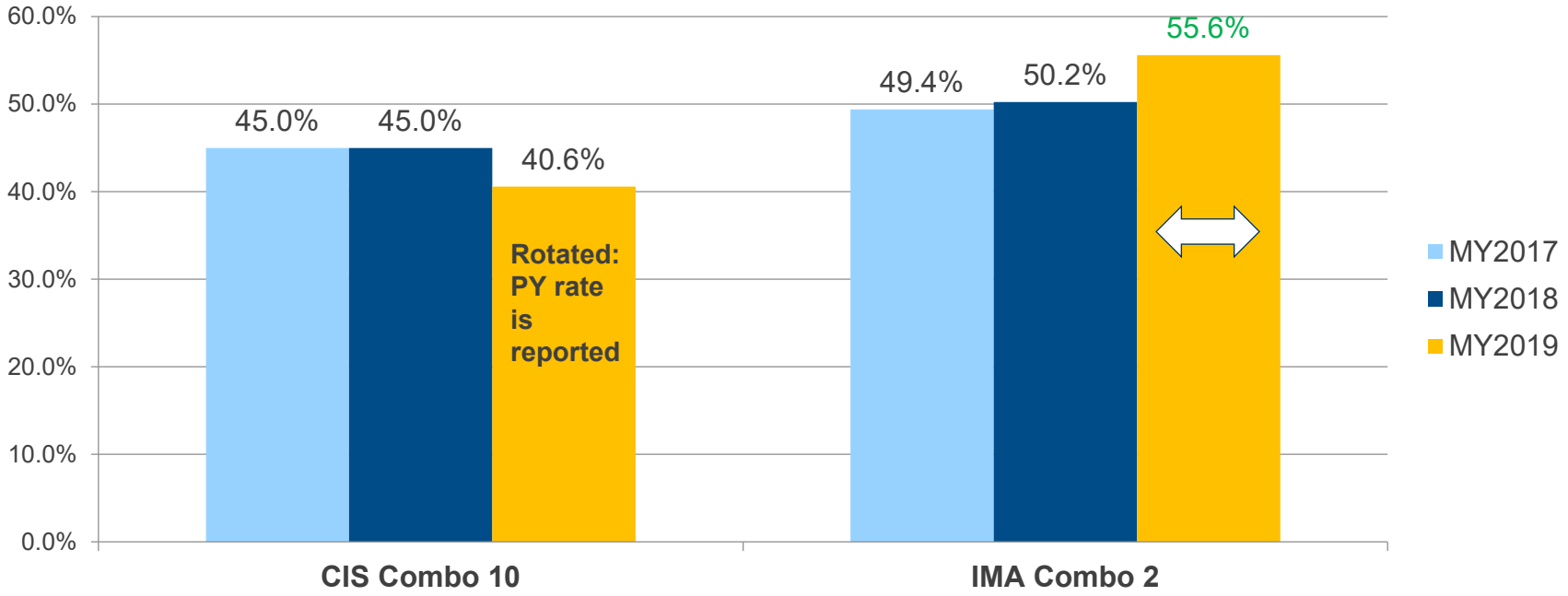
HEDIS 2020 Results: Medi-Cal Child and Adolescent Immunizations



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Childhood Immunization Status (CIS) - combo10 ++	34.79%	42.02%	49.27%	45.65%	ACC, P4V, RS, MPL
Immunizations for Adolescents (IMA) - Combo 2	34.43%	40.39%	47.2%	47.20%	ACC, RS, MPL

*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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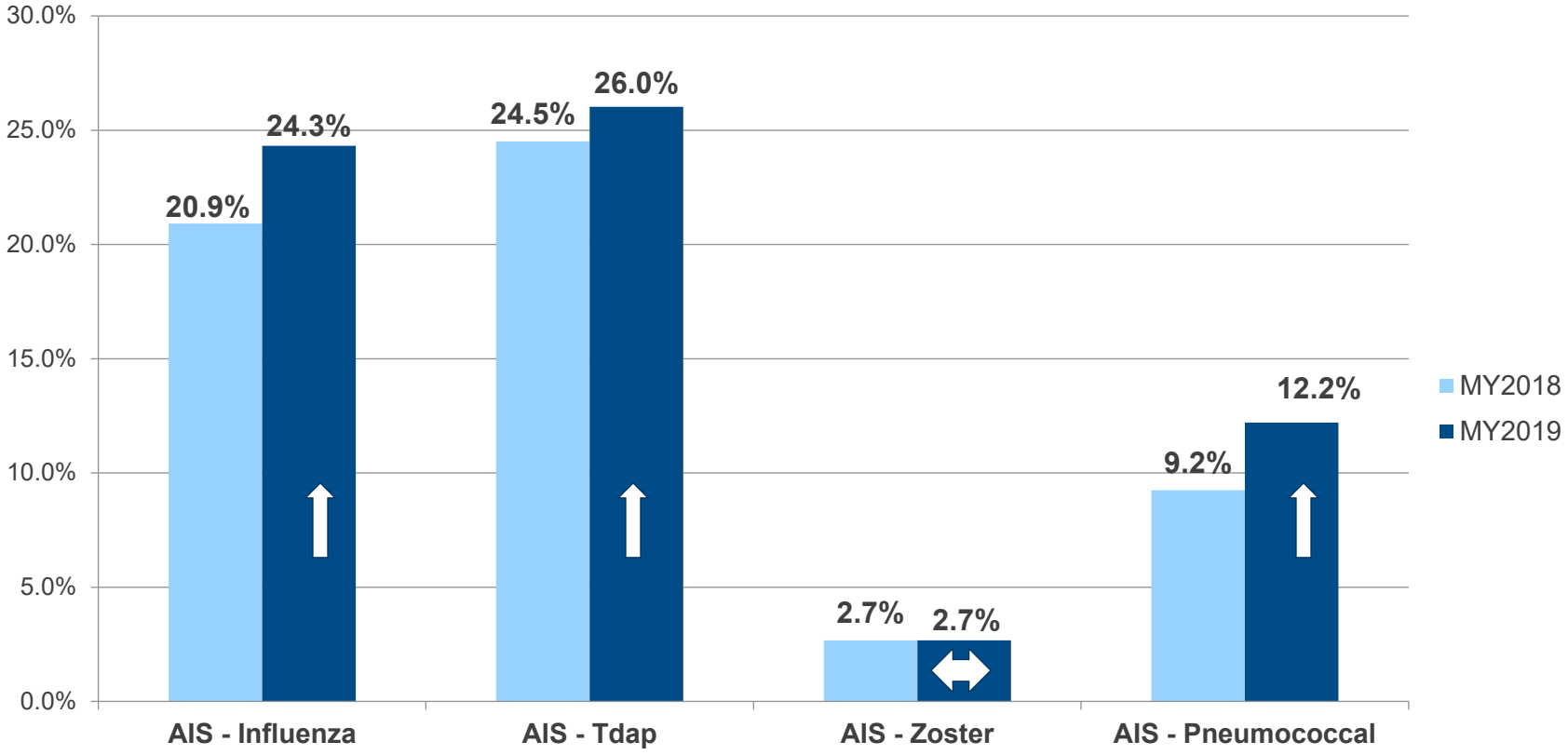
HEDIS 2020 Results: Medi-Cal Adult Immunization Status



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

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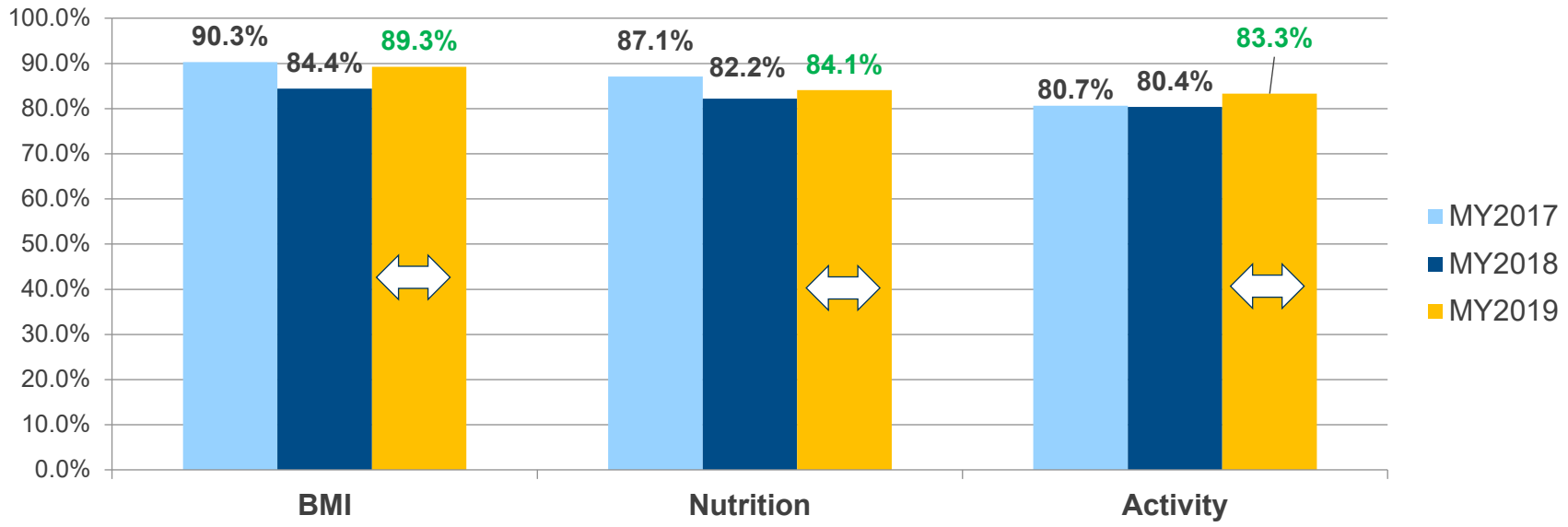
HEDIS 2020 Results: Medi-Cal Weight Assessment and Counseling



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements* *
BMI Percentile (WCC)	79.09%	85.16%	90.40%	85.16%	ACC, MPL, RS
Counseling for Nutrition (WCC)	70.92%	79.81%	85.25%	82.53%	
Counseling for Physical Activity (WCC)	64.96%	74.14%	80.35%	80.35%	

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

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Women's Reproductive Health

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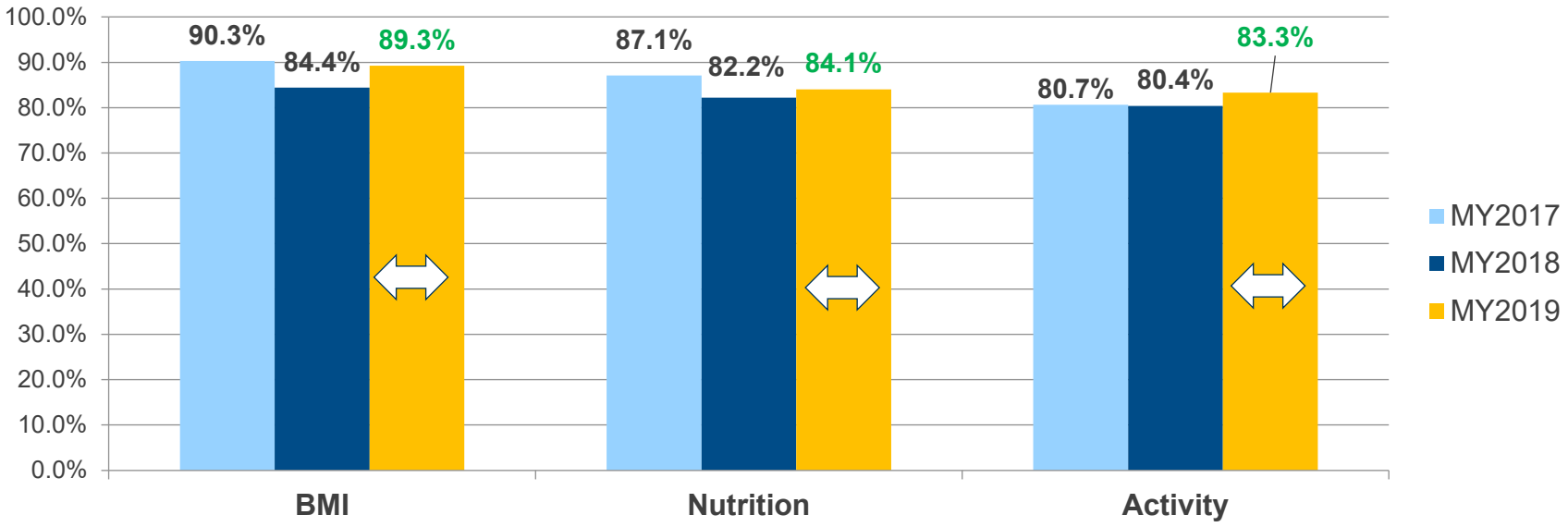
HEDIS 2020 Results: Medi-Cal Prenatal and Postpartum Care



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements* *
BMI Percentile (WCC)	79.09%	85.16%	90.40%	85.16%	ACC, MPL, RS
Counseling for Nutrition (WCC)	70.92%	79.81%	85.25%	82.53%	
Counseling for Physical Activity (WCC)	64.96%	74.14%	80.35%	80.35%	

*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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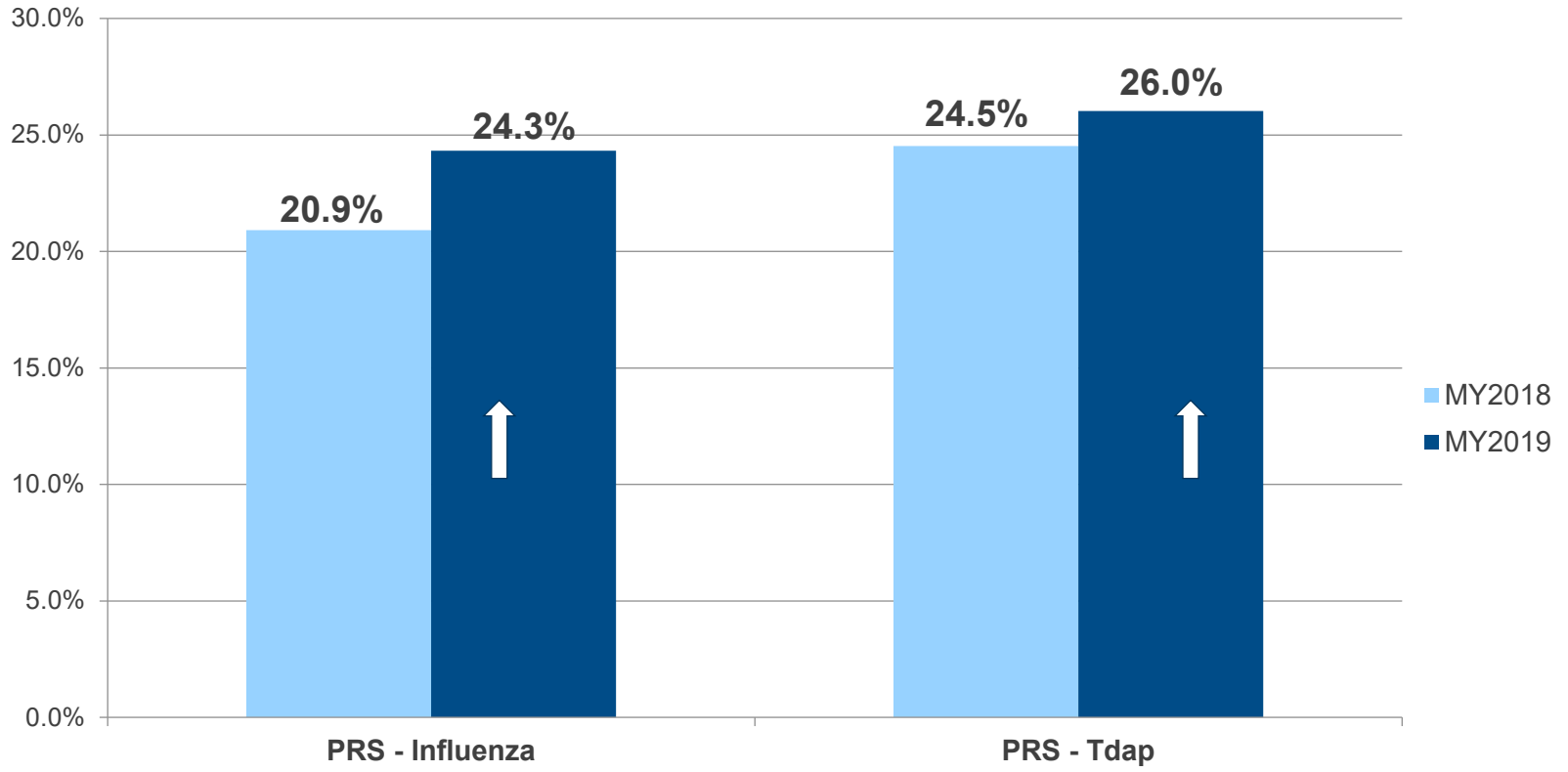
HEDIS 2020 Results: Medi-Cal Prenatal Immunization Status



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

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Prevention:
Cancer Screening

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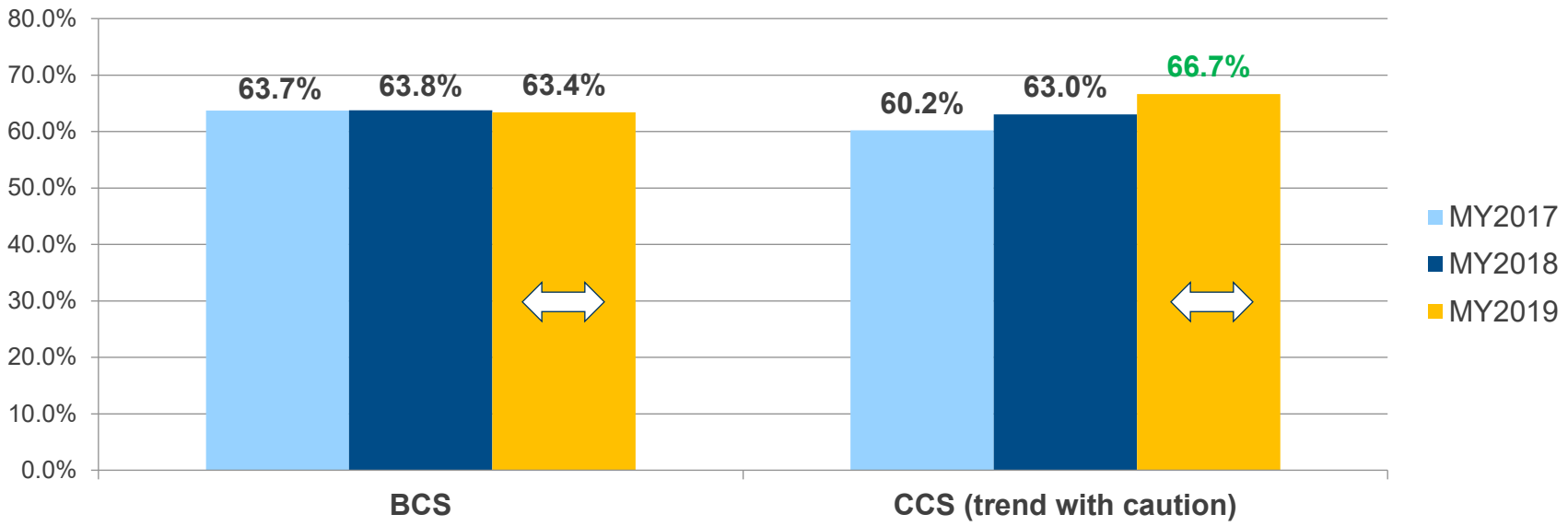
HEDIS 2020 Results: Medi-Cal Women's Health Cancer Screenings



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Breast Cancer Screening (BCS)	58.67%	63.98%	69.23%	63.98%	ACC, RS, MPL, P4V
Cervical Cancer Screening (CCS)	60.65%	66.49%	72.02%	63.99%	ACC, RS, MPL, P4V

*Red = less than 50th percentile, Green = met goal, MPL met
↑ ↓ statistically higher or lower ↔ statistically no difference
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Prevention: Other

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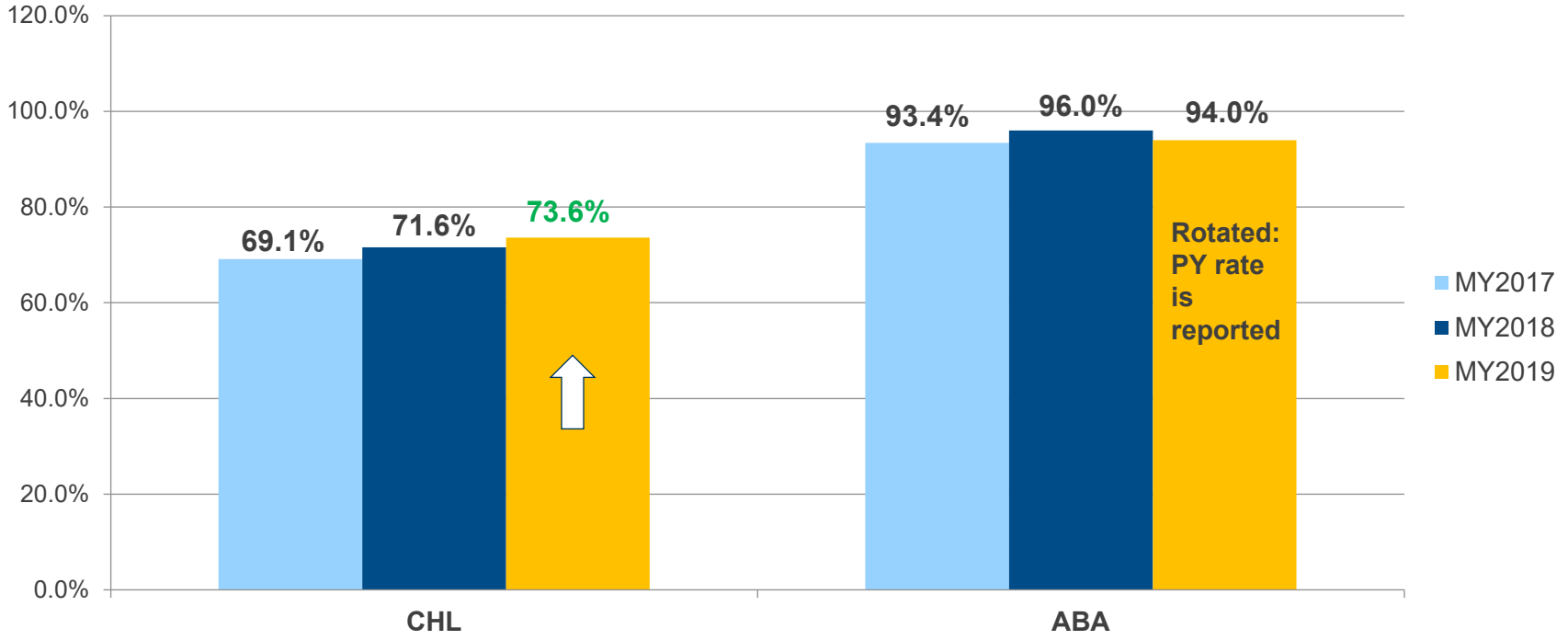
HEDIS 2020 Results: Medi-Cal Chlamydia Screening and BMI



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Chlamydia Screening (CHL)	58.34%	66.24%	71.58%	71.58%	RS, MPL
Adult BMI Assessment (ABA)	90.27%	93.67%	95.88%	95.88%	ACC, RS, MPL

*Red = less than 50th percentile, Green = met goal
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Annual Visits to PCPs

- Measures number of members in specific age groups that had at least one preventive care office visit with a PCP in the measurement year.
- Adult Visits
  - Below 50th percentile but significant improvement compared to prior year
- Pediatric Visits
  - 25 months to 6 years old showed significant improvement
  - 12 to 19 years old also showed significant improvement
  - Trend with caution

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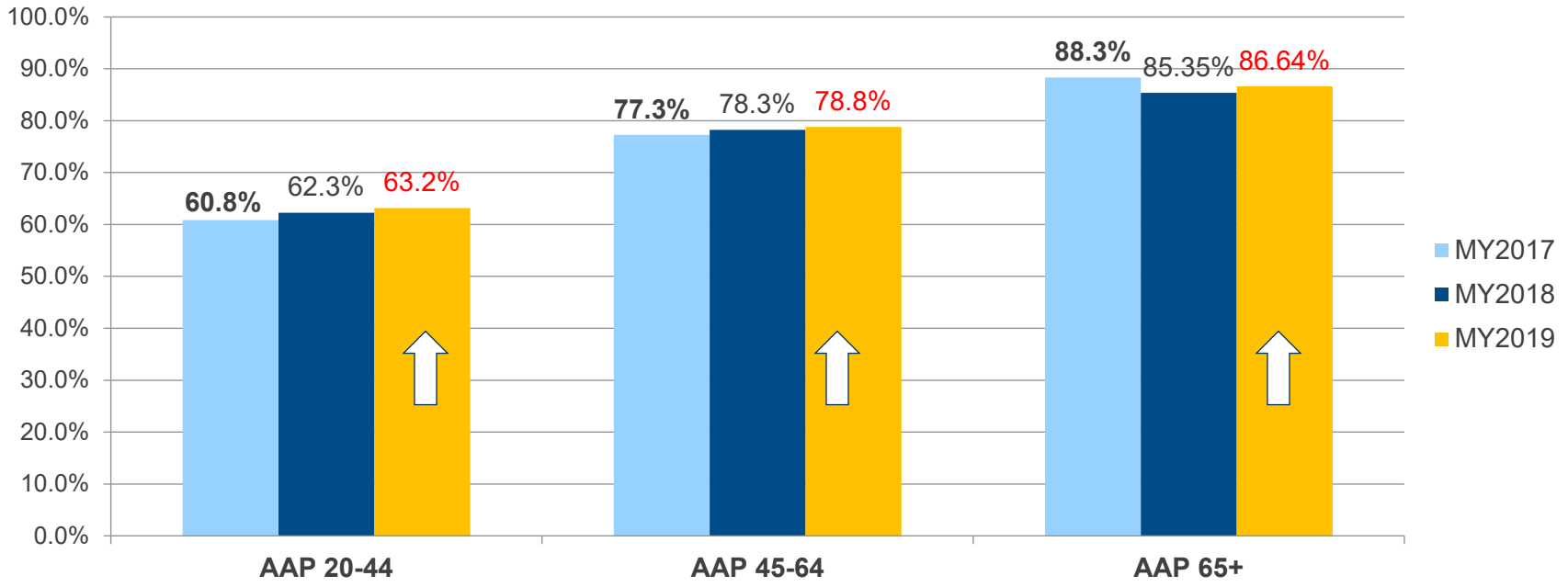
HEDIS 2020 Results: Medi-Cal Annual Visits to PCP's: Adults



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Adult's Access to Preventive/Ambulatory Services (AAP) 20-44	78.63%	82.36%	85.30%	71.59%	P4V
Adult's Access to Preventive/Ambulatory Services (AAP) 45-64	86.32%	88.84%	90.88%	81.68%	P4V
Adult's Access to Preventive/Ambulatory Services (AAP) 65+	88.07%	92.07%	94.70%	88.07%	P4V

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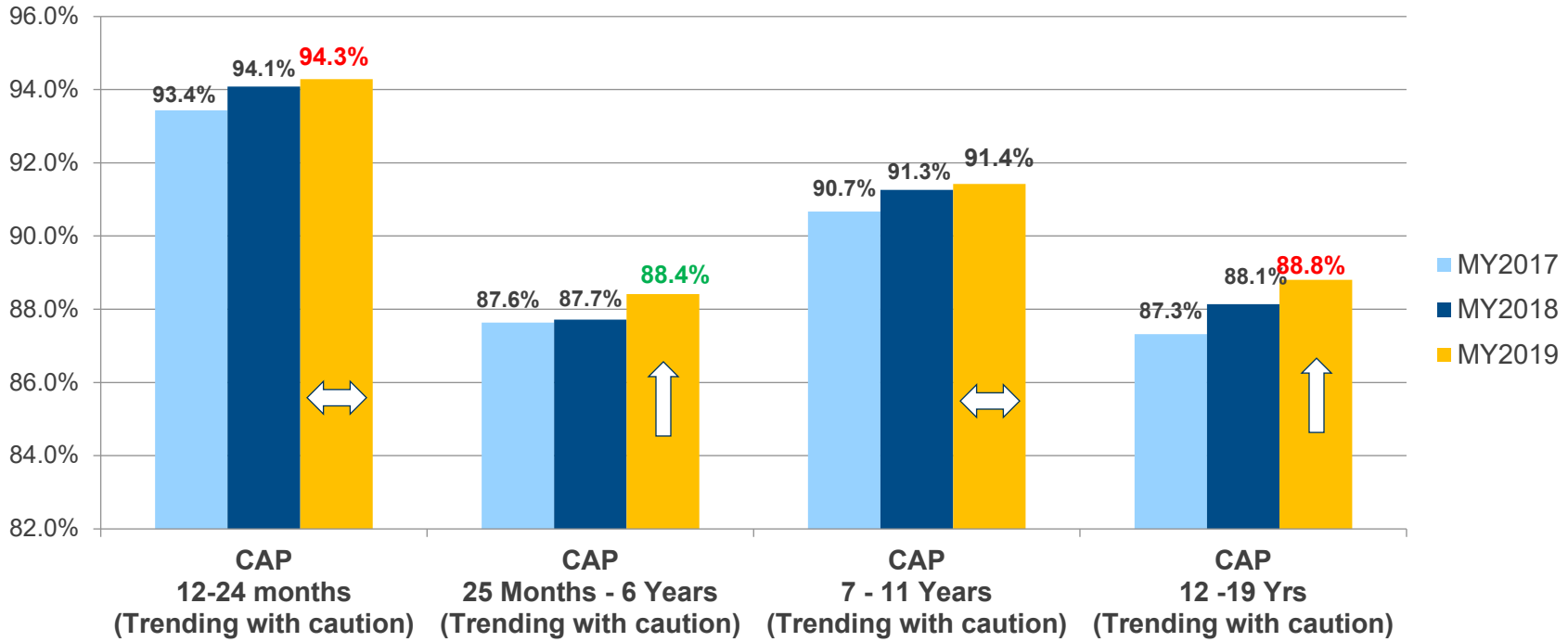
HEDIS 2020 Results: Medi-Cal Annual Visits to PCP's : Children



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Children's Access to Primary Care Practitioners (CAP)					
12 - 24 Months	95.62%	97.04%	97.82%	95.62%	
25 Months - 6 Years	87.87%	90.32%	92.59%	87.87%	
7 - 11 Years	91.08%	93.41%	95.85%	92.33%	
12 -19 Years	90.21%	92.29%	94.64%	90.21%	P4V

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Treatment:
Respiratory Conditions

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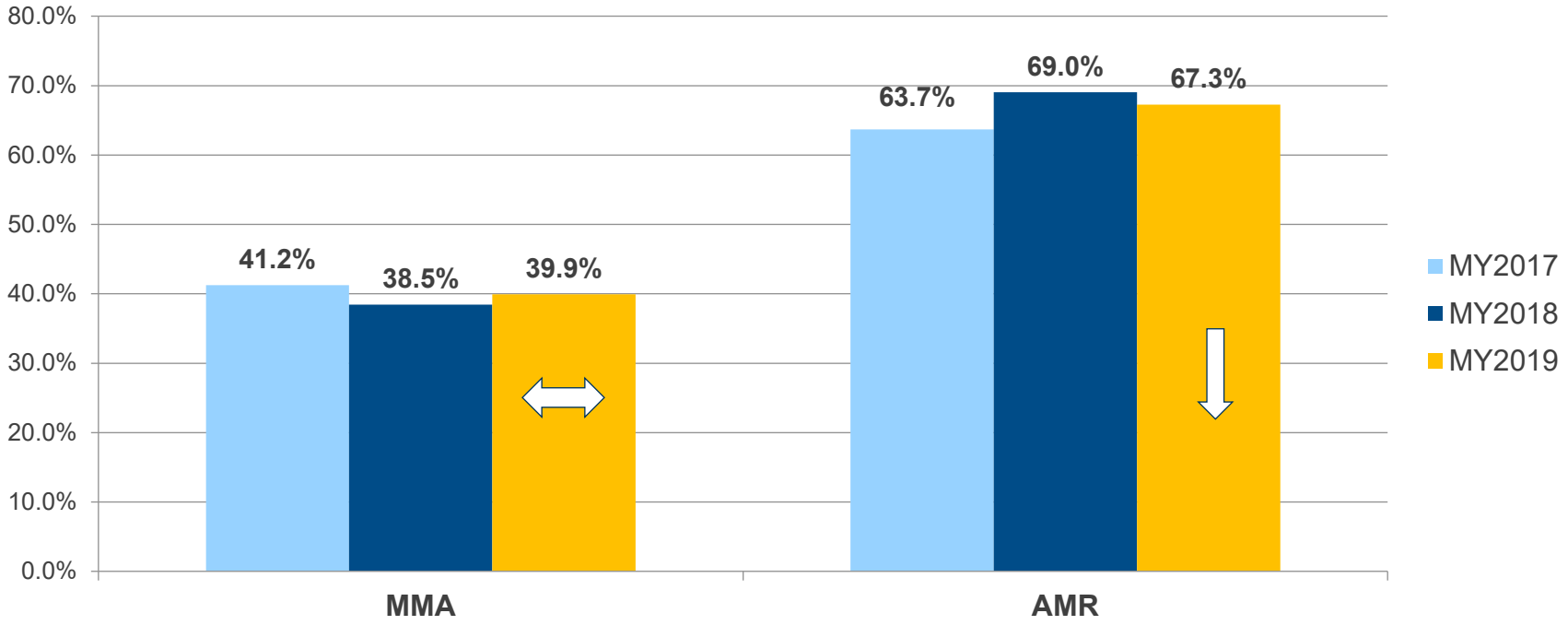
HEDIS 2020 Results: Medi-Cal Asthma Treatment



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Medication Management for People with Asthma (MMA) 5 to 64 years 75% Compliance	37.01%	42.77%	49.05%	40.93%	ACC, RS
Asthma Medication Ratio >50% (AMR) 5 to 64 years	63.58%	68.52%	71.62%	70.07%	ACC, MPL, RS

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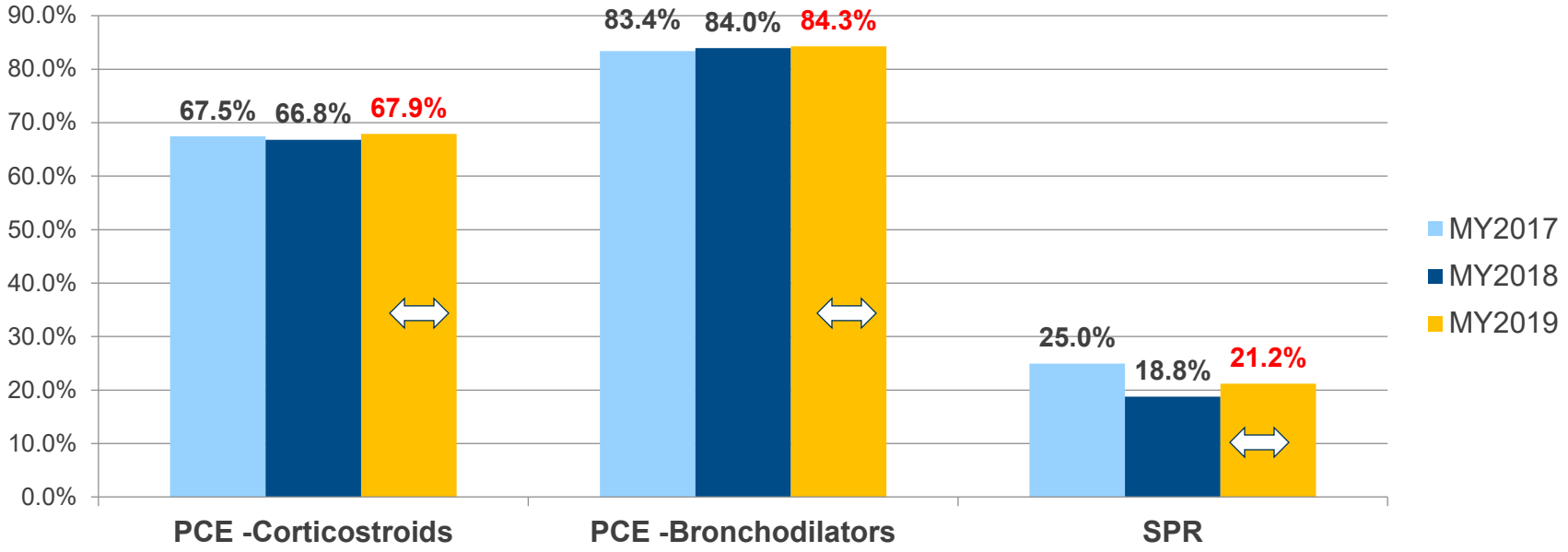
HEDIS 2020 Results: Medi-Cal COPD



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Pharmacotherapy Management of COPD Exacerbation (PCE) Systemic Corticosteroids	71.02%	75.38%	81.13%	71.02%	ACC, RS
Pharmacotherapy Management of COPD Exacerbation (PCE) Bronchodilators	83.67%	87.6%	89.66%	84.62%	ACC, RS
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.39%	34.76%	41.07%	25.04%	

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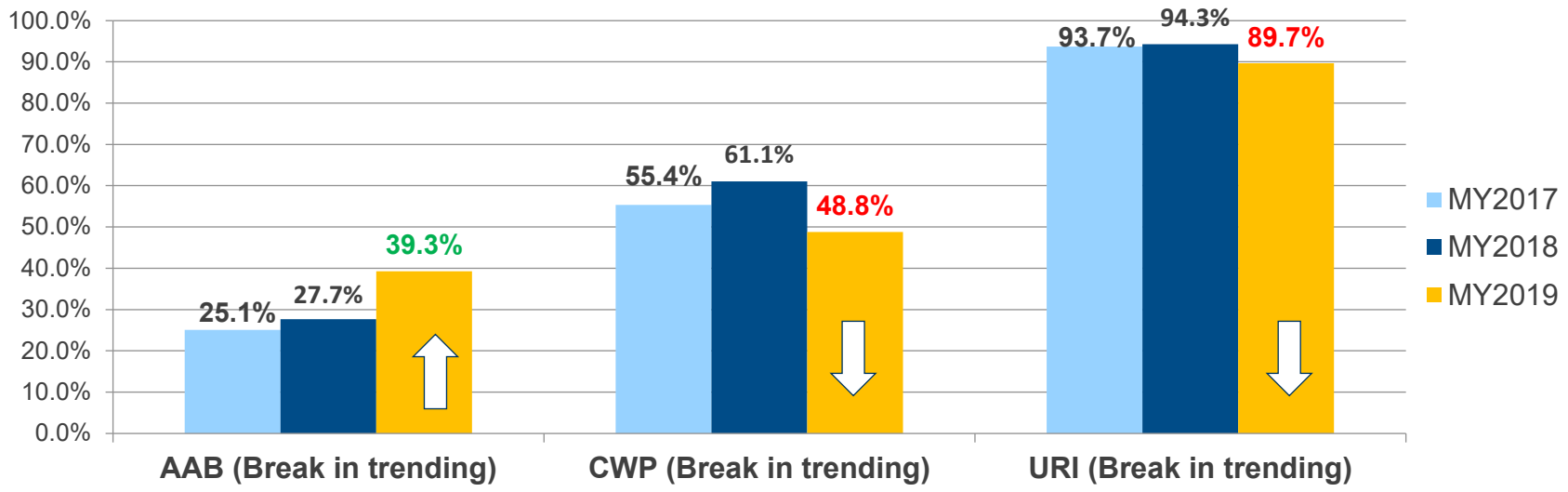
HEDIS 2020 Results: Medi-Cal Respiratory Conditions



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	34.23%	41.07%	48.88%	29.85%	ACC, RS, P4V
Appropriate Testing for Children with Pharyngitis (CWP)	81.46%	86.51%	90.77%	74.79%	ACC, RS, P4V
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	91.85%	94.88%	96.79%	94.88%	ACC, RS, P4V

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Treatment: Diabetes

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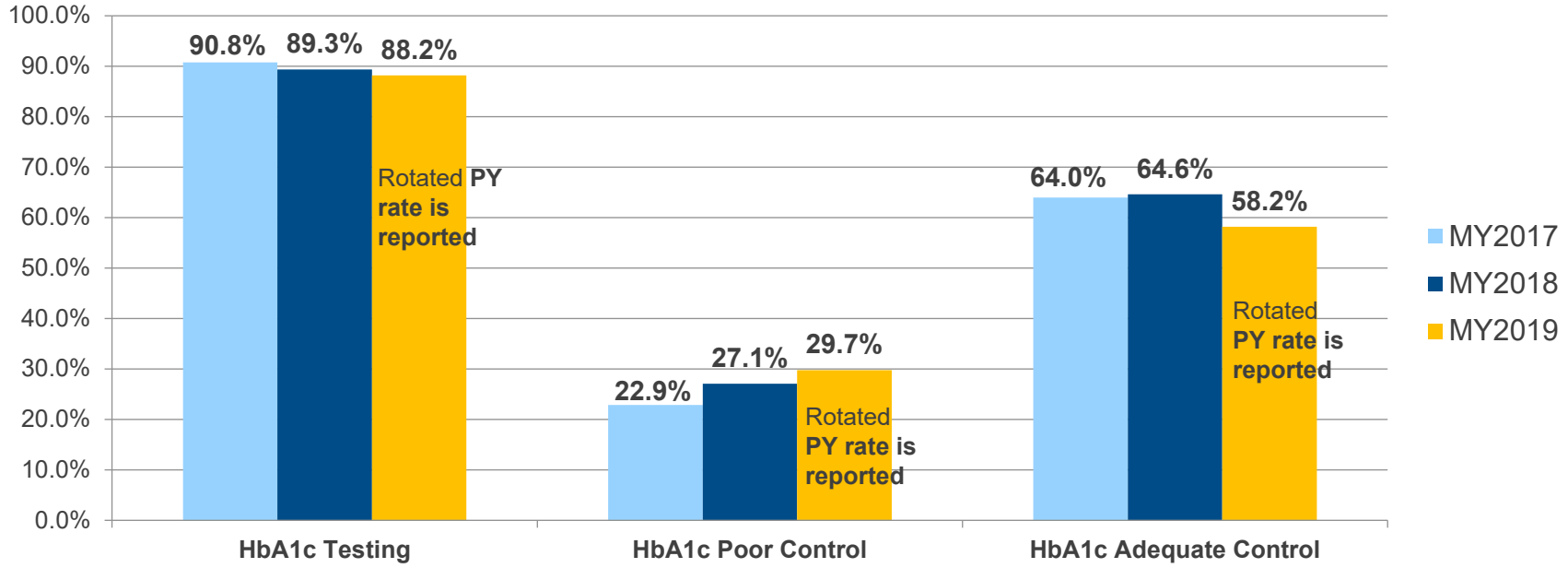
HEDIS 2020 Results: Medi-Cal Comprehensive Diabetes Care – HbA1c



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
HbA1c Testing	88.55%	90.51%	92.94%	89.78%	MPL
HbA1c Poor Control (>9.0%) (Lower is better)	38.52%	32.85%	27.98%	27.98%	MPL
HbA1c Adequate Control (<8.0%) ++	50.97%	55.96%	60.77%	60.77%	ACC, RS, P4V

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++ measure triple weighted for Health Plan Ratings
↑ ↓ statistically higher or lower ↔ statistically no difference
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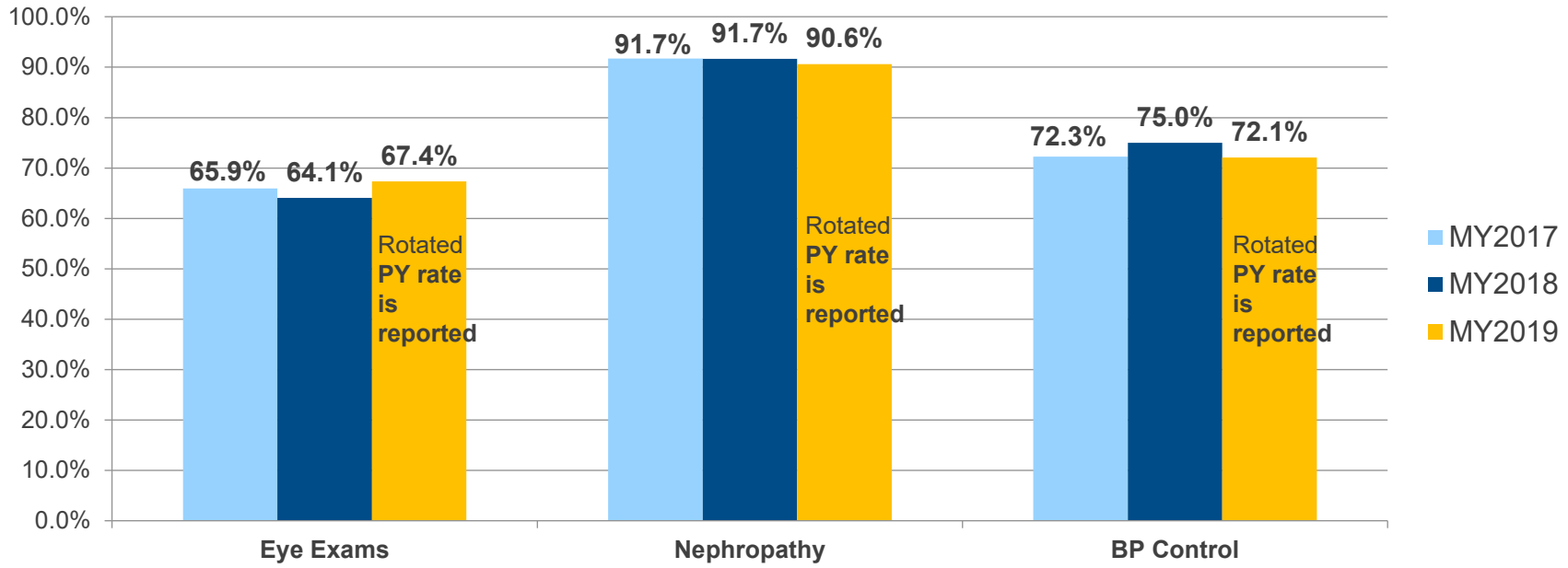
HEDIS 2020 Results: Medi-Cal Comprehensive Diabetes Care



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Eye Exams	57.88%	64.23%	68.61%	64.72%	ACC, RS, P4V
Nephropathy Monitoring	90.51%	92.05%	93.43%	91.85%	
BP Control (<140/90) ++	63.02%	70.76%	77.5%	77.17%	ACC, RS

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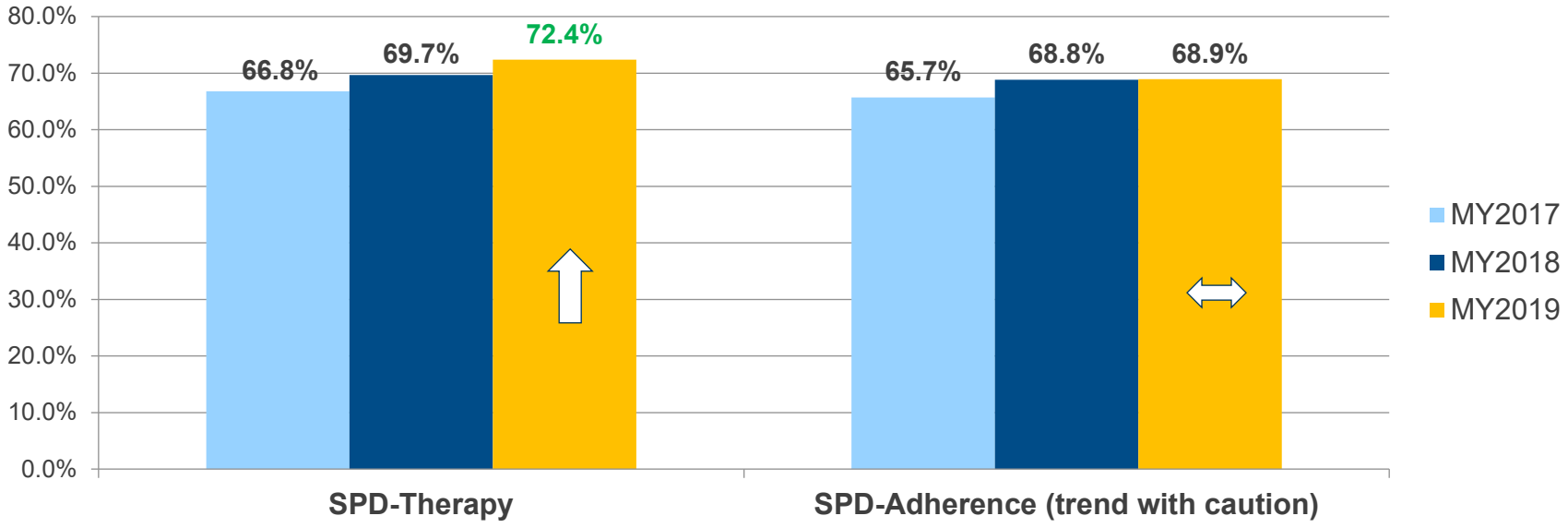
HEDIS 2020 Results: Medi-Cal Diabetes Conditions



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) - therapy	63.65%	67.19%	70.19%	70.19%	ACC, RS
Statin Therapy for Patients with Diabetes (SPD) - adherence	59.11%	64.62%	72.03%	71.00%	ACC, RS

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Treatment: Cardiovascular Conditions

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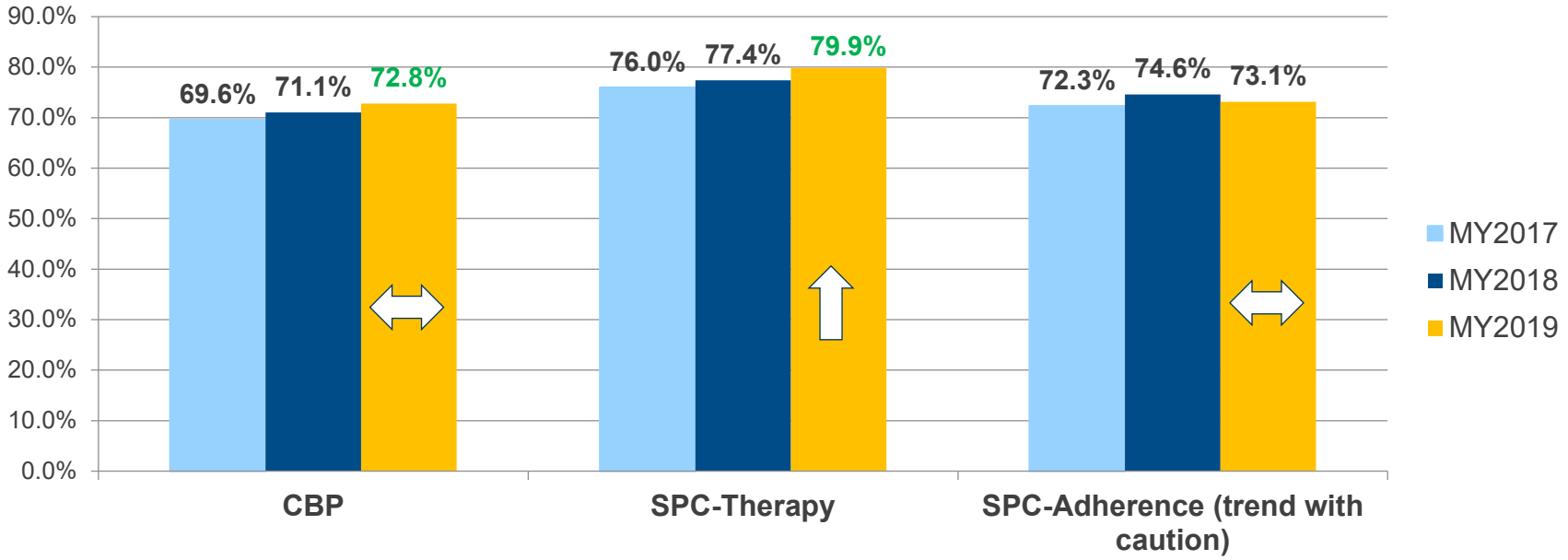
HEDIS 2020 Results: Medi-Cal Cardiovascular Conditions



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Controlling High-Blood Pressure (CBP) ++	61.04%	66.91%	72.26%	72.26%	ACC, MPL, RS
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Therapy	77.57%	81.24%	83.62%	77.57%	ACC. RS
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Adherence	65.28%	69.97%	74.29%	74.29%	ACC, RS

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Treatment:
Behavioral Health (BH)

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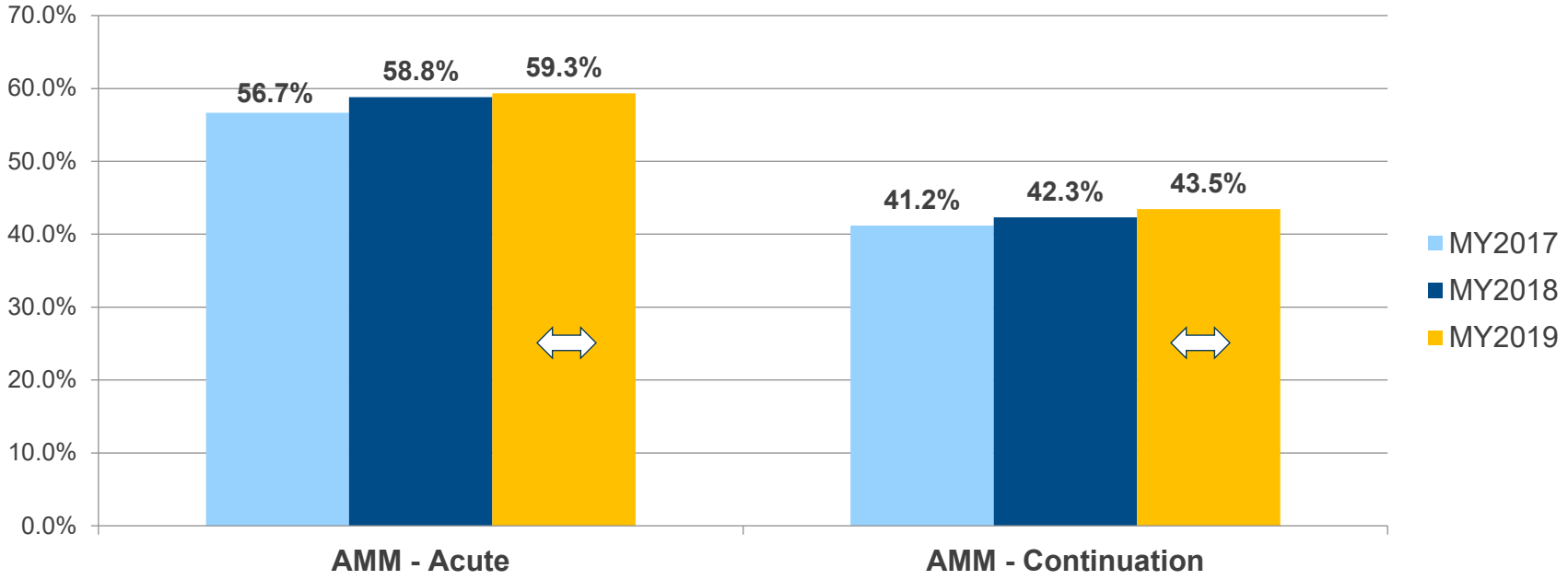
HEDIS 2020 Results: Medi-Cal
BH Antidepressant Medication Management



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) Acute Phase Treatment	52.33%	56.41%	65.95%	61.18%	MPL
Antidepressant Medications Management (AMM) Continuation Phase Treatment	36.51%	40.95%	48.68%	44.82%	ACC, RS, MPL

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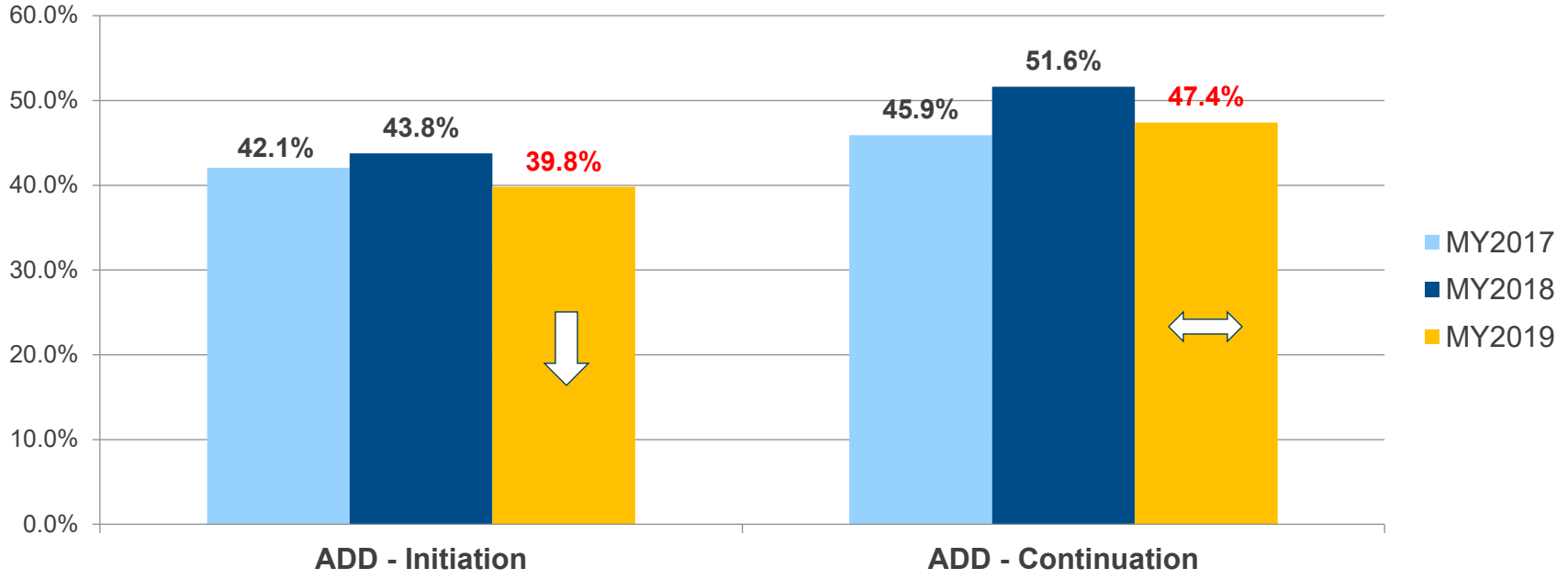
HEDIS 2020 Results: Medi-Cal BH: Attention Deficit Disorder



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	43.41%	49.86%	56.57%	48.00%	MPL
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	55.50%	62.69%	69.15%	55.50%	ACC, MPL, RS

*Red = less than 50th percentile, Green= met goal
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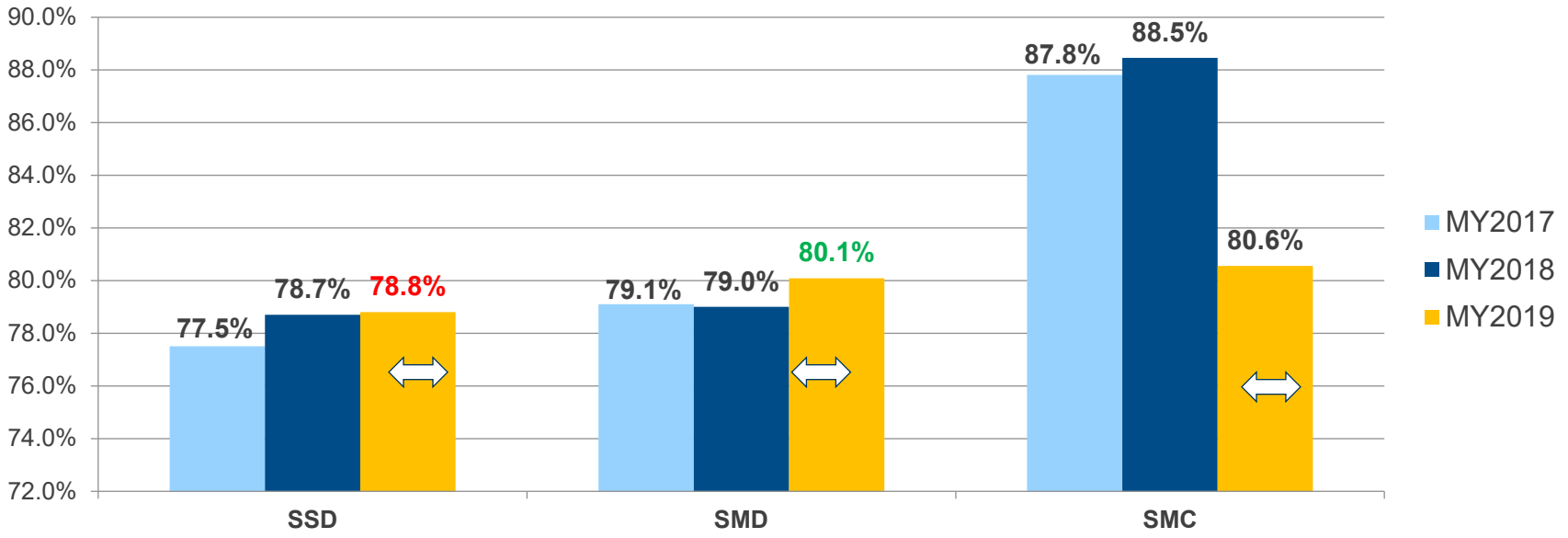
HEDIS 2020 Results: Medi-Cal
BH: Schizophrenia or Bipolar Disorder



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications (SSD)	81.04%	84.27%	86.76%	81.04%	ACC, RS
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	71.62%	76.28%	79.50%	79.50%	
Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia (SMC)	77.71%	84.75%	89.16%	89.16%	

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++ measure triple weighted for Health Plan Ratings
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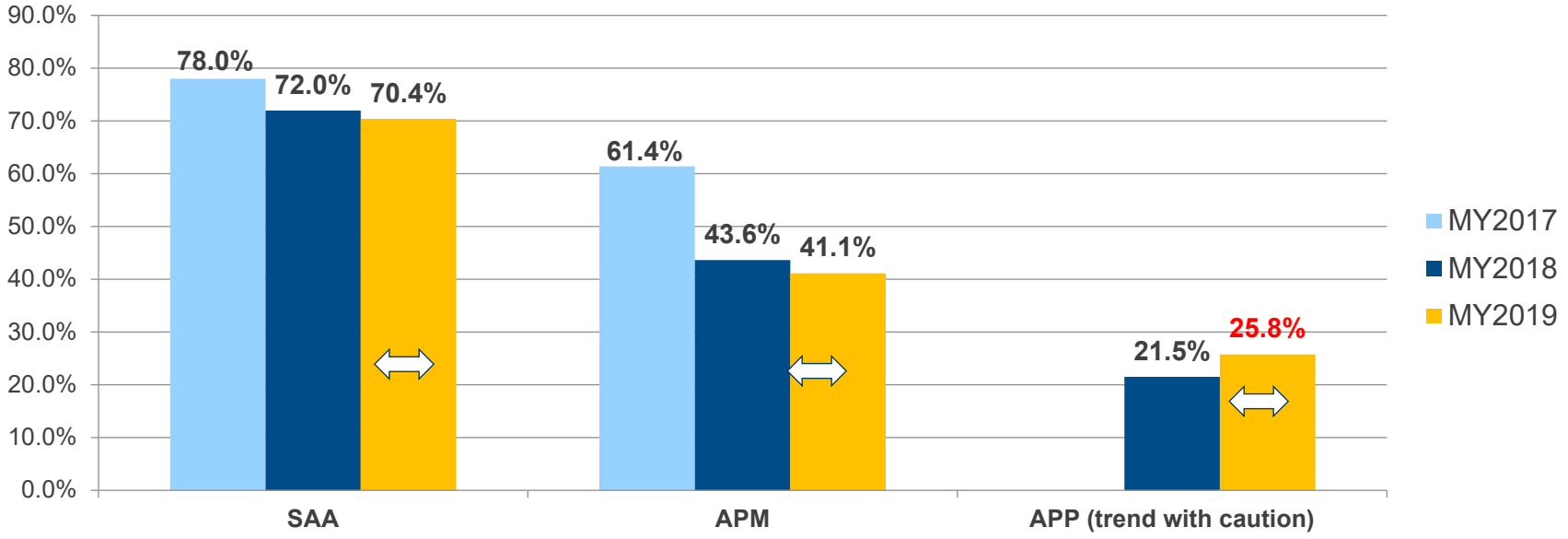
HEDIS 2020 Results: Medi-Cal BH: Antipsychotic Medications



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	61.36%	67.47%	71.77%	71.77%	ACC, RS
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	33.33%	40.90%	49.08%	44.99%	ACC, RS
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	60.63%	66.58%	75.04%	52.67%	ACC, RS

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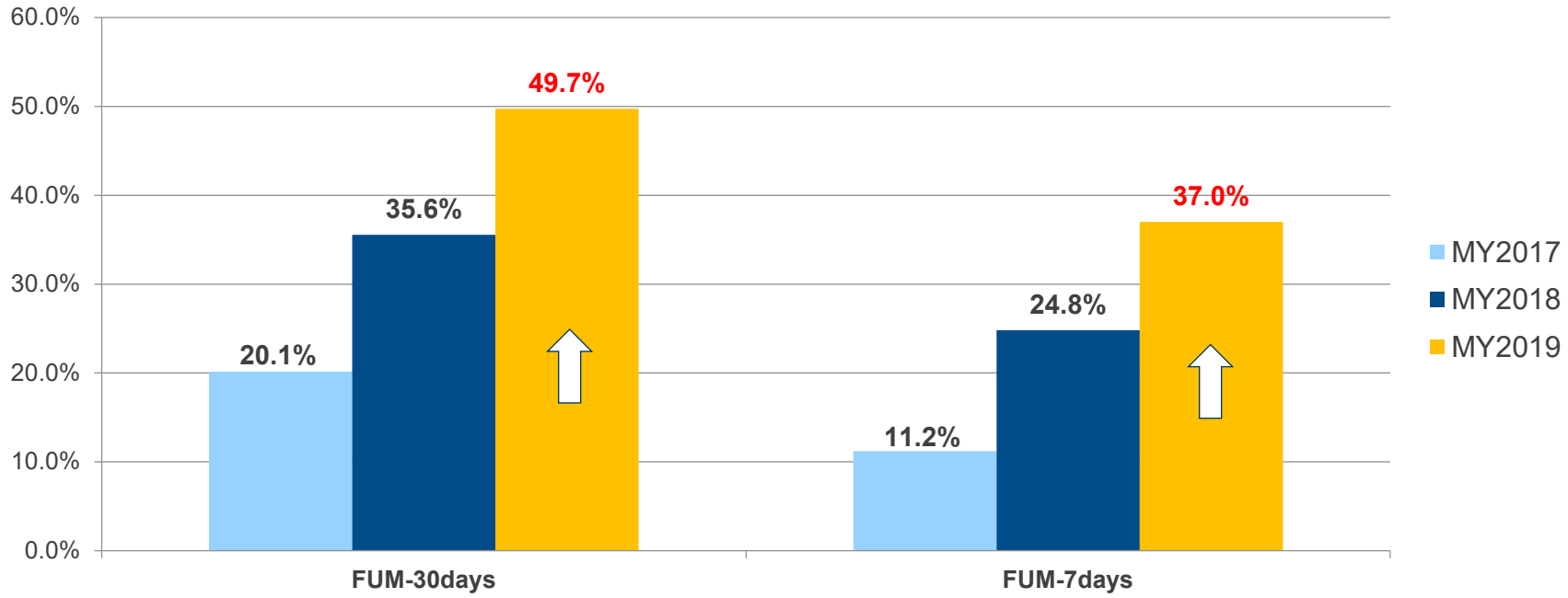
HEDIS 2020 Results: Medi-Cal BH: Follow-up after ED Visits



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-up After ED visit for Mental Illness (FUM 30-day)	52.59%	66.04%	74.30%	44.48%	
Follow-up After ED visit for Mental Illness (FUM 7-day)	37.04%	51.93%	60.63%	28.37%	RS

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Opioid Use and Treatment

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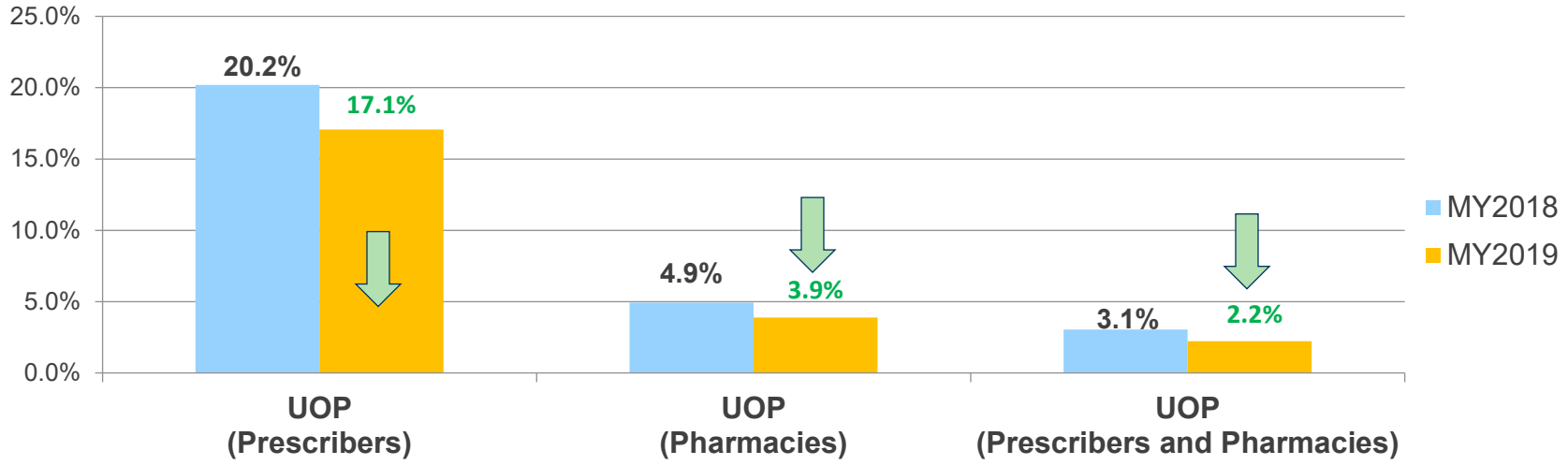
HEDIS 2020 Results: Medi-Cal Use of Opioids



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Use of Opioids From Multiple Providers (UOP) - multiple Prescribers	21.71%	18.2%	15.29%	19.74%	RS
Use of Opioids From Multiple Providers (UOP) - multiple Pharmacies	6.09%	4.19%	2.08%	4.88%	RS
Use of Opioids From Multiple Providers (UOP) - multiple Prescribers and Pharmacies	3.46%	2.14%	0.99%	2.48%	RS

*Red = less than 50th percentile, Green = met goal, MPL met
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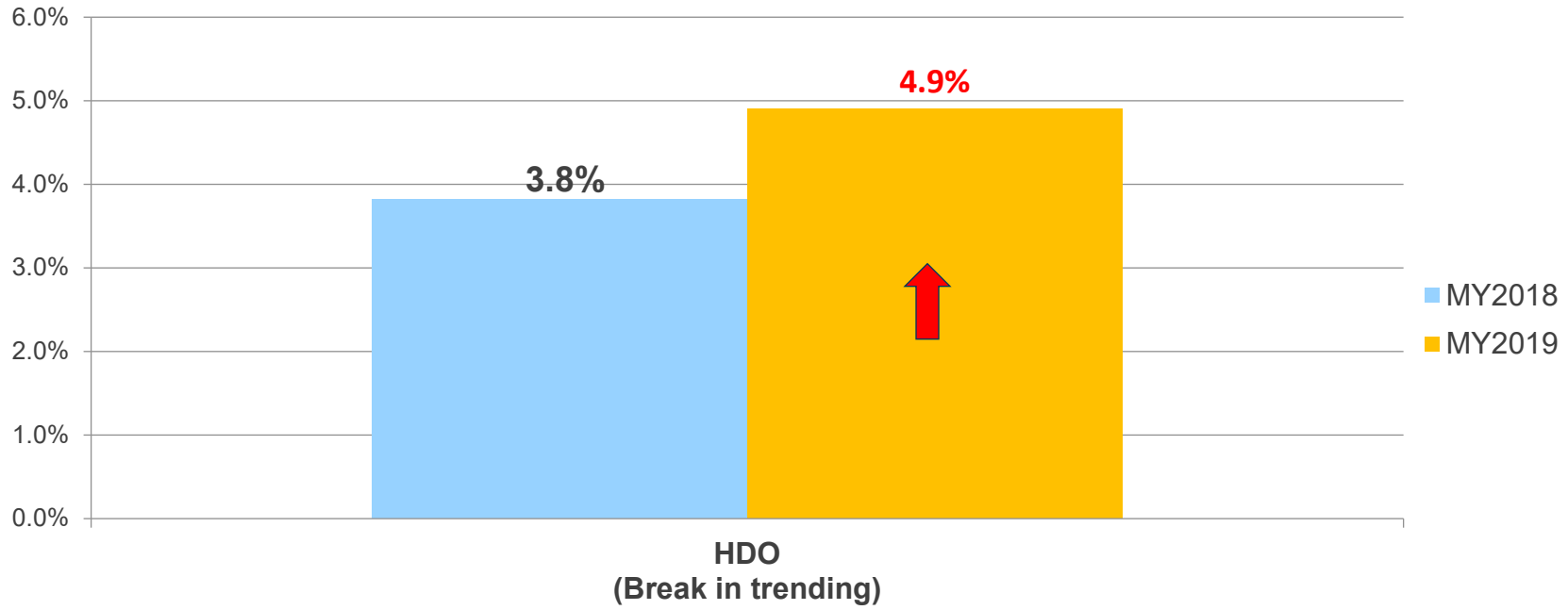
HEDIS 2020 Results: Medi-Cal Use of Opioids



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Use of Opioids at High Dosage (HDO) Lower rate is better	4.55%	2.27%	1.28%	2.82%	RS

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MY2019 OCC Measures

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Comprehensive Diabetes Care — HbA1c Poor Control (>9.0%) (lower rate is better)	4 Star	4 Star
Comprehensive Diabetes Care (Eye Exam)	5 Star	5 Star
Comprehensive Diabetes Care (Medical Attention for Nephropathy)	4 Star	5 Star
Statin Therapy for Patients with Diabetes — Therapy	25th	**75th**
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)	50th	90th
Osteoporosis Management in Women Who Had a Fracture	4 Star	4 Star
Transitions of Care (Notification Discharge)	75th	75th
Use of high-risk medications in Older Adults	75th	75th

*Green = higher than last year; Red = lower than last year, +C = trend with caution due to specification changes per NCQA, Highlighted yellow = Break in trending

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MY2019 OCC Measures (cont.)

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Breast Cancer Screening	2 Star	**3 Star**
Colorectal Cancer Screening (C02)	3 Star	3 Star
Care for Older Adults (SNP) — Pain assessment	3 Star	3 Star
Pharmacotherapy management of COPD exacerbations (Bronchodilator)	50th	50th
Statin Therapy for Patients with Cardiovascular Disease — Adherence **+C**	25th	**50th**
Comprehensive Diabetes Care (Blood Pressure Controlled <140/90 mm Hg)	50th	50th
Statin Therapy for Patients with Diabetes — Adherence **+C**	25th	**50th**
DMARD Therapy in Rheumatoid Arthritis	2 Star	**3 Star**
Antidepressant Medications Management (Acute Phase Treatment)	<=10th	**50th**
Follow-up After ED visit for Mental Illness (30-day)	25th	**50th**
Follow-up After ED visit for Mental Illness (7-day)	<=10th	**50th**
Use of Opioids From Multiple Providers (multiple Prescribers)	25th	**50th**
Use of Opioids From Multiple Providers (multiple Pharmacies)	25th	**50th**
Use of Opioids From Multiple Providers (multiple Prescribers and Pharmacies)	25th	**50th**

*Green = higher than last year; Red = lower than last year; +C = trend with caution due to specification changes per NCQA, Highlighted yellow = Break in trending

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MY2019 OCC Measures (cont.)

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Adult BMI Assessment	4 Star	**3 Star**
Care for Older Adults (SNP) — Medication Review	3 Star	3 Star
Controlling High-Blood Pressure	50th	50th
Comprehensive Diabetes Care — HbA1c Control (<8.0%)	50th	50th
Transitions of Care (Med Reconciliation)	50th	50th

*Green = higher than last year; Red = lower than last year; +C = trend with caution due to specification changes per NCQA, Highlighted yellow = Break in trending

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MY2019 OCC Measures (cont.)

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Care for Older Adults (SNP) — Functional status assessment	2 Star	2 Star
Statin Therapy for Patients with Cardiovascular Disease — Therapy	1 Star	**2 Star**
Comprehensive Diabetes Care — HbA1c testing	<=10th	**25th**
Antidepressant Medications Management (Acute Phase Treatment)	<=10th	**25th**
Follow-up After Hospitalization for Mental Illness (30–day)	25th	25th
Follow-up After ED visit for Alcohol and Other Drug Dependence (7–day)	<=10th	**25th**
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	<=10th	**25th**
Medication Reconciliation Post-Discharge	2 Star	2 Star
Transitions of Care (Receipt Discharge Info)	25th	25th
Transitions of Care (Engmt. after discharge)	50th	**25th**

*Green = higher than last year; Red = lower than last year; +C = trend with caution due to specification changes per NCQA, Highlighted yellow = Break in trending

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MY 2019 OCC Measures (cont.)

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	<=10th	<=10th
Follow-up After ED visit for Alcohol and Other Drug Dependence (30–day)	<=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
Plan All-Cause readmissions (65+)	1 Star	1 Star
Engagement of Alcohol and Other Drug Dependence Treatment	<=10th	<=10th
Initiation of Alcohol and Other Drug Dependence Treatment	<=10th	<=10th
Follow-up After Hospitalization for Mental Illness (7-day)	<=10th	<=10th
Pharmacotherapy management of COPD exacerbations (Corticosteroid)	<=10th	<=10th
Non-Recommended PSA-Based Screening in Older Men	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (age 20–44)	25th	**<=10th**
Adults' Access to Preventive/Ambulatory Health Services (age 45–64)	<=10th	<=10th

*Green = higher than last year; Red = lower than last year; +C = trend with caution due to specification changes per NCQA, Highlighted yellow = Break in trending

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Three Year Trended Results OneCare Connect (OCC) MY2017-2019

Benchmarks: NCQA National Medicare HEDIS MY 2018 Percentile

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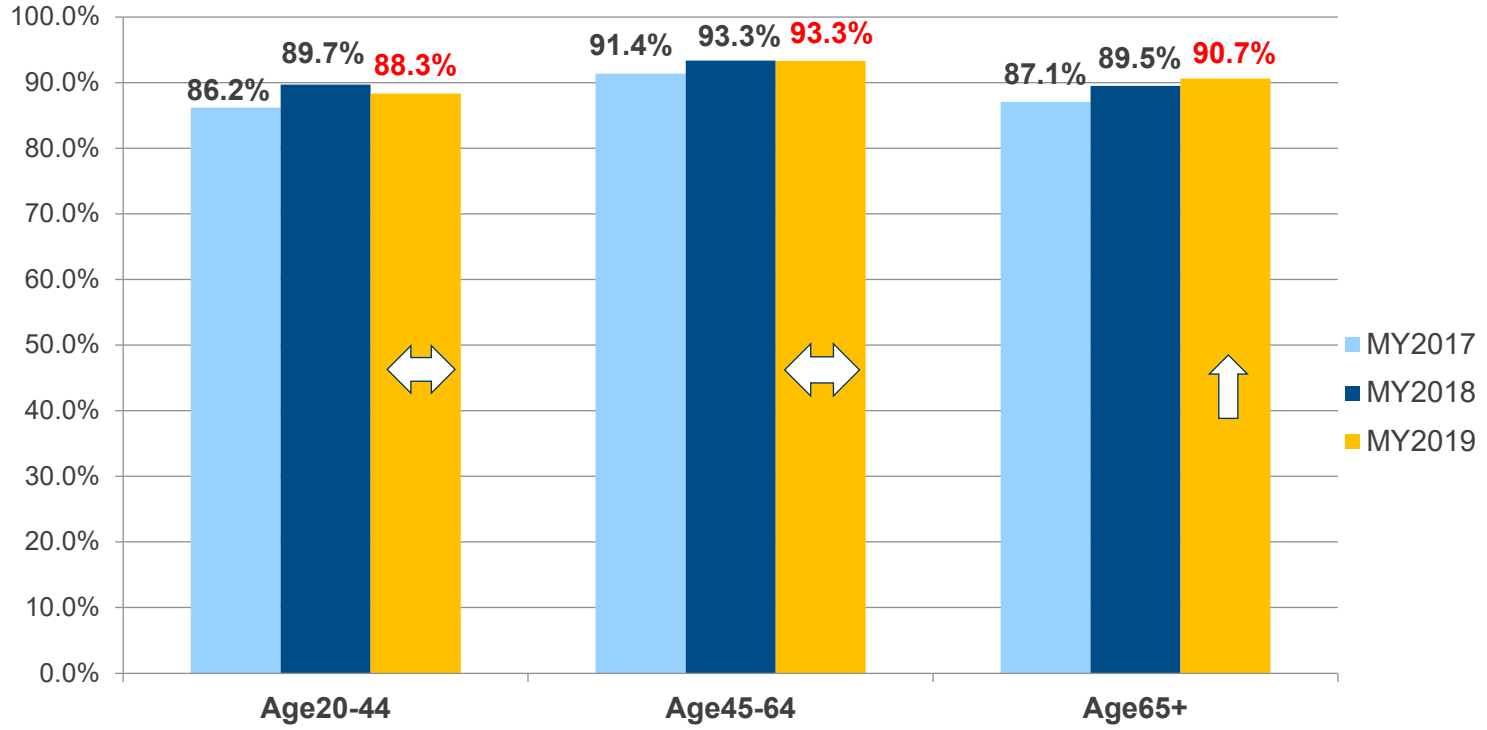
HEDIS 2020 Results: OCC Annual Visits to PCP's



HEDIS Measure	50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Adult's Access to Preventive/Ambulatory Health Services (AAP)					
Age 20-44	92.07%	94.36%	96.52%	92.07%	CMS
Age 45-64	96.29%	97.40%	98.56%	94.73%	CMS
Age 65+	95.87%	97.12%	98.55%	93.80%	CMS

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

↑ ↓ statistically higher or lower ↔ statistically no difference

*P4V = Pay for Value

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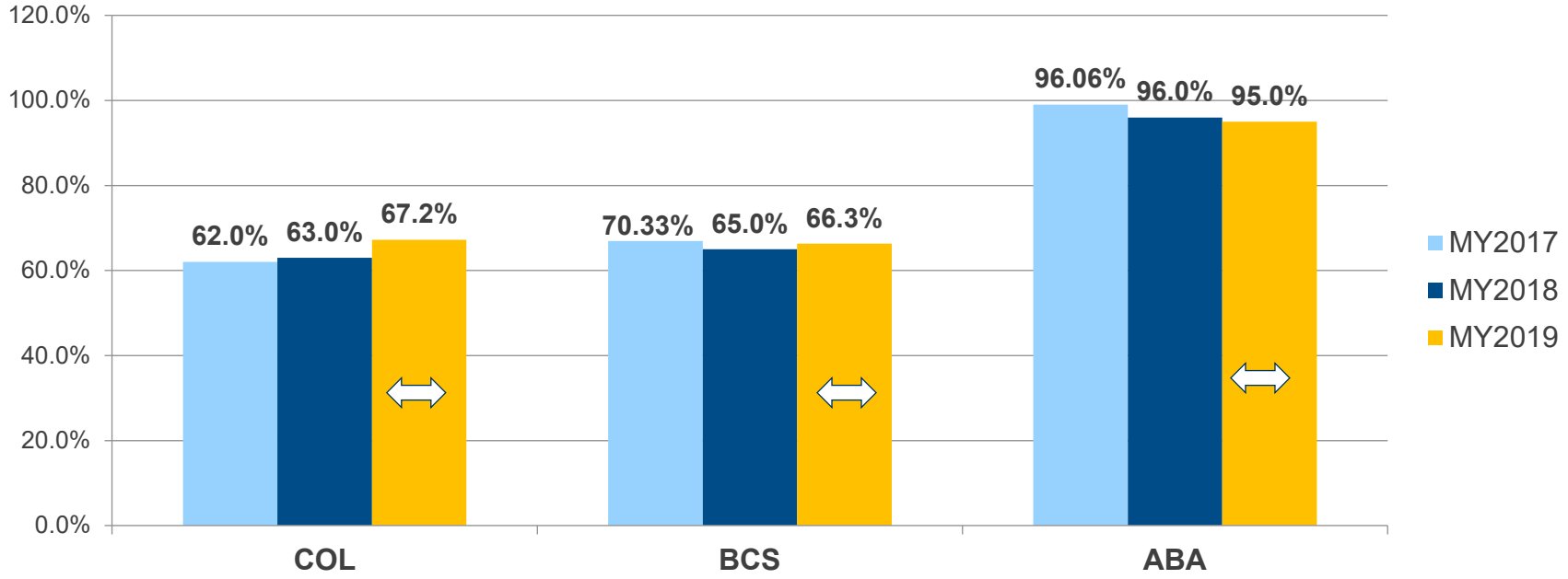
HEDIS 2020 Results: OCC Prevention and Screening



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Colorectal Cancer Screening (COL)	62%	73%	80%	73%	Star, P4V
Breast Cancer Screening (BCS)	66%	76%	83%	66%	Star, P4V
Adult BMI Assessment (ABA)	92%	96%	99%	99%	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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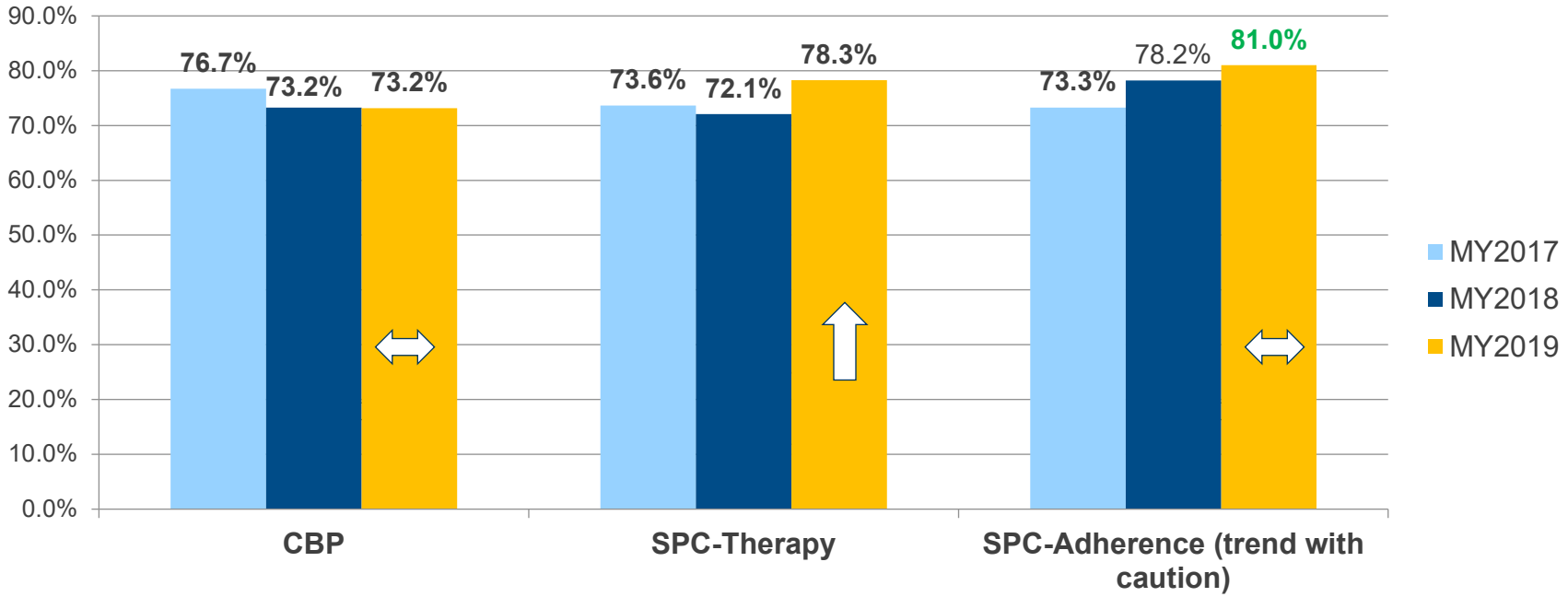
HEDIS 2020 Results: OCC Cardiovascular



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Colorectal Cancer Screening (COL)	62%	73%	80%	73%	Star, P4V
Breast Cancer Screening (BCS)	66%	76%	83%	66%	Star, P4V
Adult BMI Assessment (ABA)	92%	96%	99%	99%	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

Triple weighted for STARS

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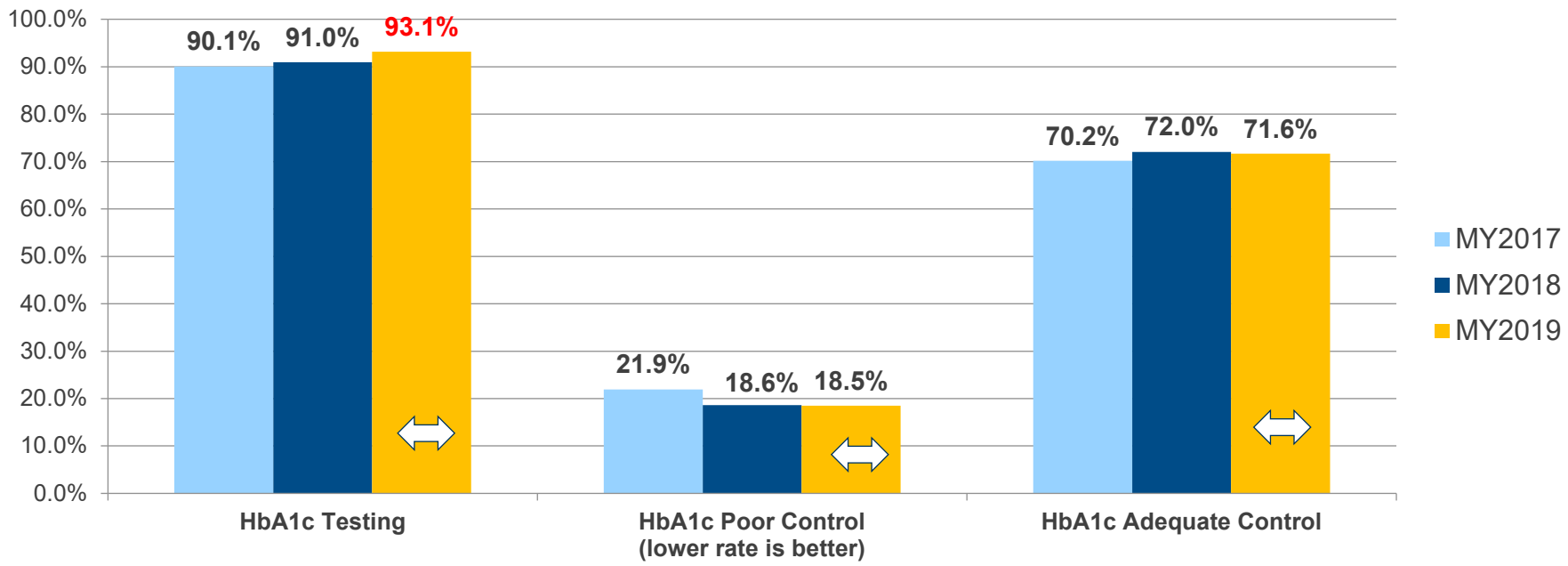
HEDIS 2020 Results: OCC Comprehensive Diabetes Care — HbA1c



HEDIS Measure	3-Star/ 50th percentile	4-Star/ 75th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements*
Comprehensive Diabetes Care (CDC) — HbA1c Testing	94.89%	96.38%	97.32%	93.00%	CMS
Comprehensive Diabetes Care (CDC) — HbA1c Poor Control (>9.0%) **	39%	28%	15%	15%	Star, P4V
Comprehensive Diabetes Care (CDC) — HbA1c Adequate Control (<8.0%)	68.57%	73.57%	77.78%	71.97%	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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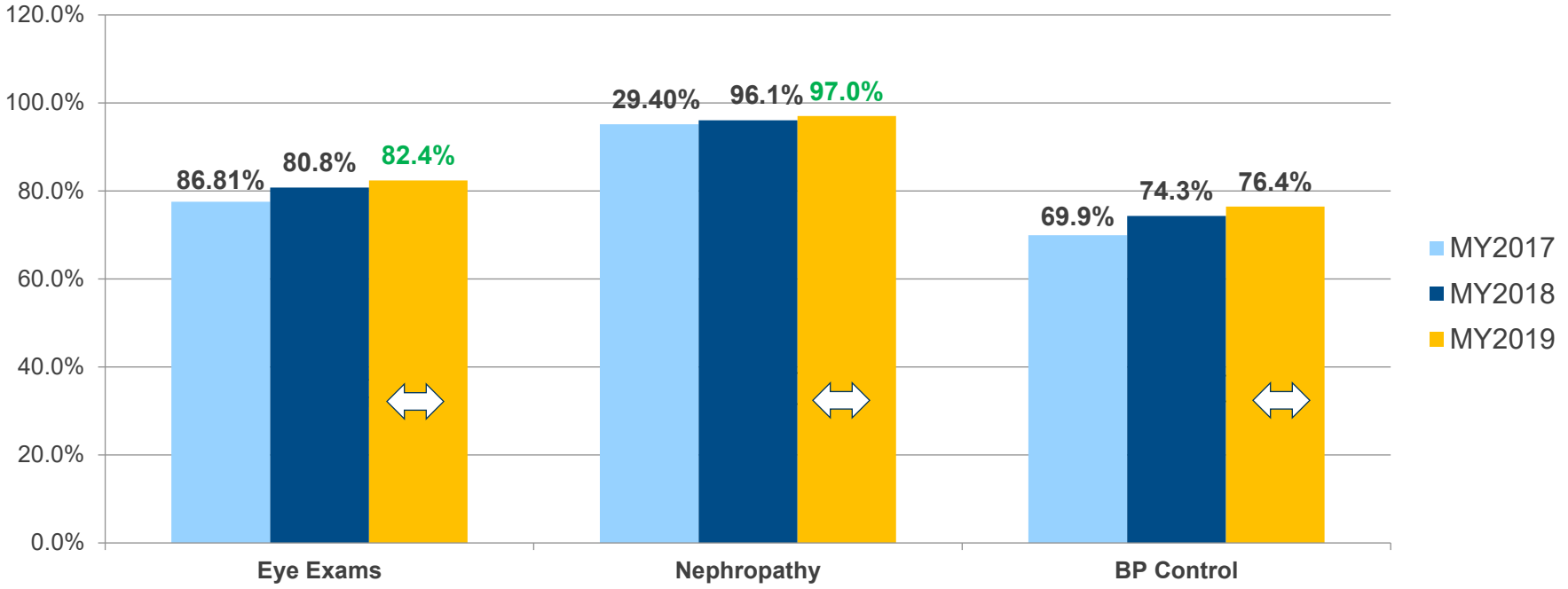
HEDIS 2020 Results: OCC Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 50th percentile	4-Star/ 75th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements*
Comprehensive Diabetes Care (CDC) — Eye Exams	69%	73%	78%	78%	Star, P4V
Comprehensive Diabetes Care (CDC) — Nephropathy Monitoring	80%	95%	97%	97%	Star
Comprehensive Diabetes Care (CDC) — BP Control (<140/90)	69.53%	76.56%	81.50%	76.56%	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

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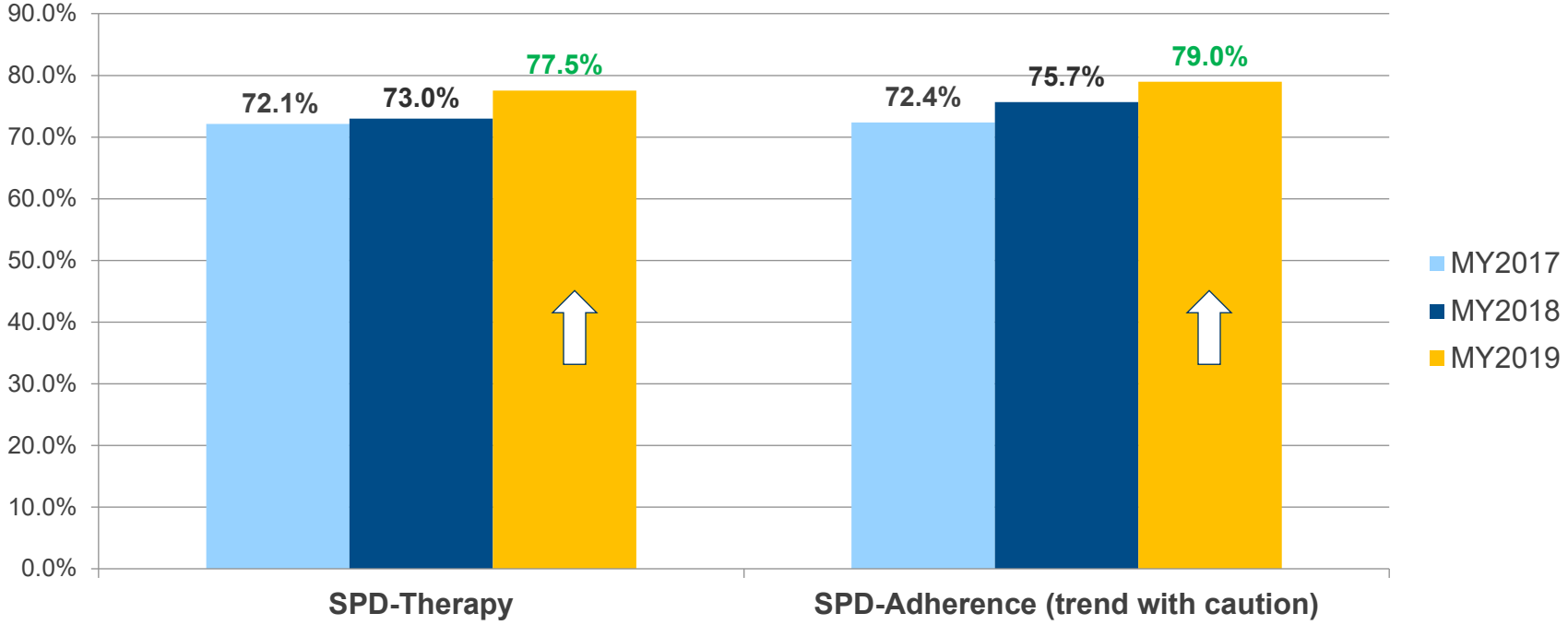
HEDIS 2020 Results: OCC Diabetes Conditions



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) — Therapy	74.13%	77.43%	80.99%	74.13%	CMS
Statin Therapy for Patients with Diabetes (SPD) — Adherence	78.03%	81.82%	86.13%	78.03%	CMS

*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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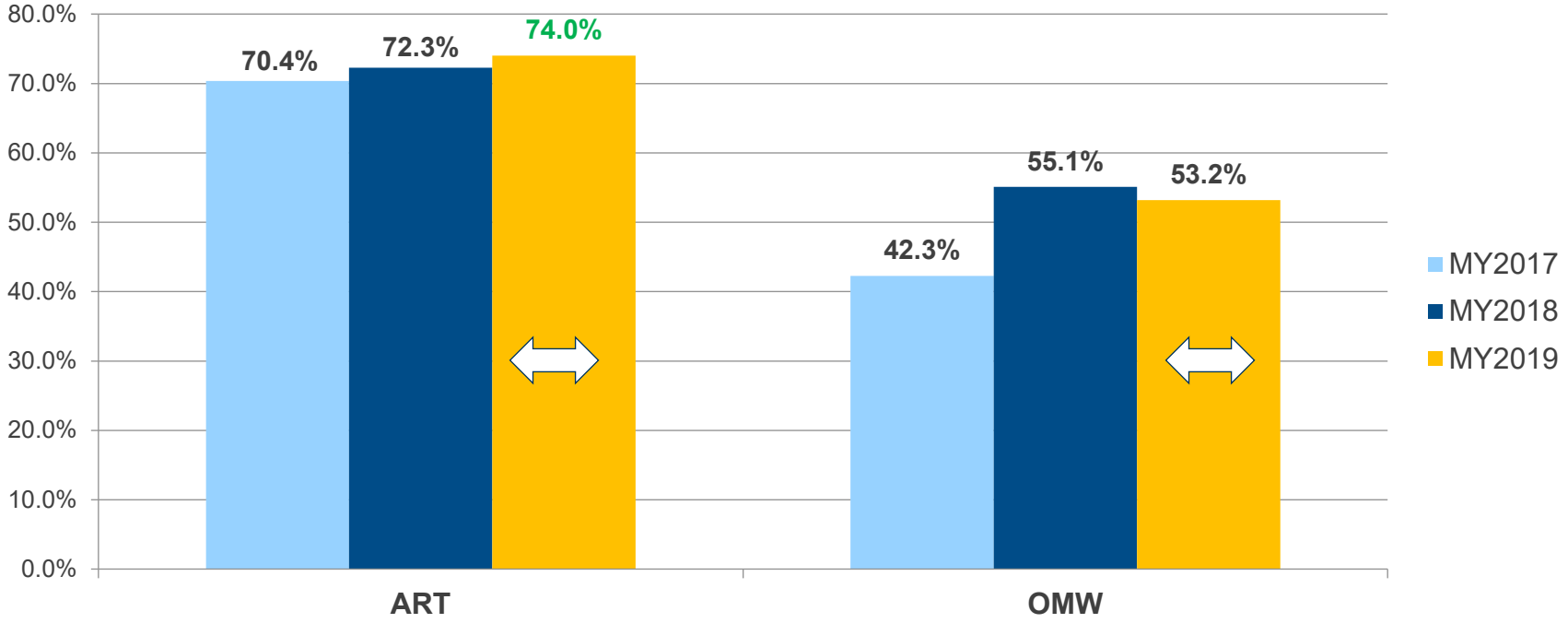
HEDIS 2020 Results: OCC Musculoskeletal Conditions



HEDIS Measure	3-Star	4-Star	5-Star	Goal	Reporting Requirements**
DMARD Therapy in Rheumatoid Arthritis (ART)	74%	79%	84%	74%	Star
Osteoporosis Management in Women Who Had a Fracture (OMW)	41%	50%	67%	67%	Star

*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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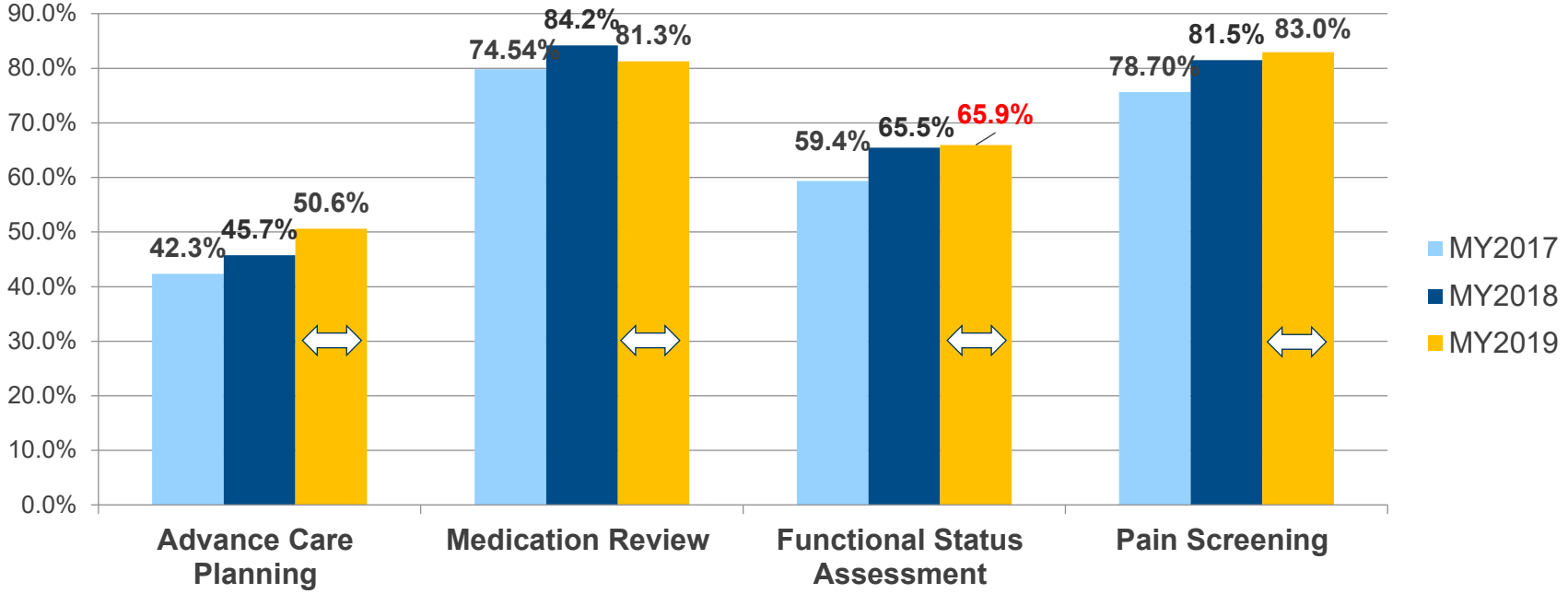
HEDIS 2020 Results: OCC Care for Older Adults



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Care for Older Adults — Advance Care Planning	No Benchmarks				CMS
Care for Older Adults — Medication Review	77%	87%	95%	87%	Star
Care for Older Adults — Functional Status Assessment	71%	85%	93%	71%	Star
Care for Older Adults — Pain Screening	81%	86%	94%	86%	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)

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↑ ↓ statistically higher or lower ↔ statistically no difference

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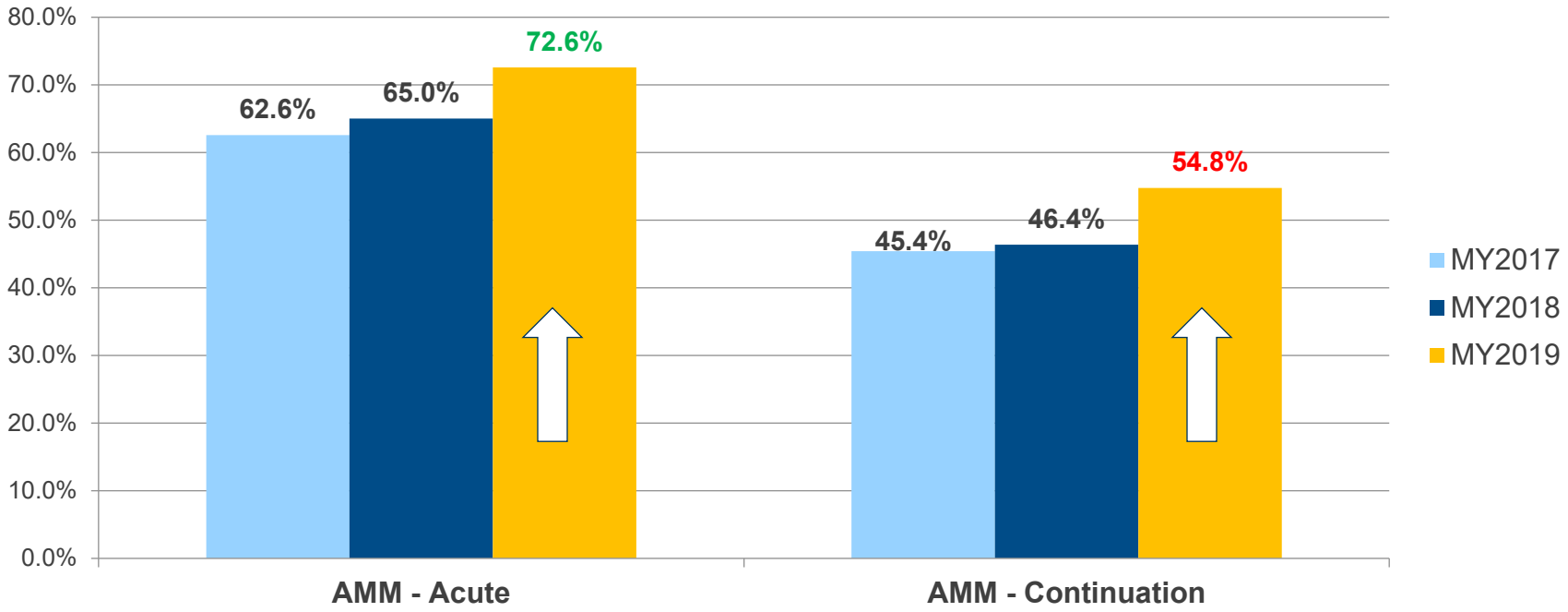
HEDIS 2020 Results: OCC Behavioral Health



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Antidepressant Medications Management (AMM) — Acute Phase Treatment	71.60%	77.19%	83.33%	66.91%	CMS
Antidepressant Medications Management (AMM) — Continuation Phase Treatment	56.17%	61.31%	67.07%	50.39%	CMS

*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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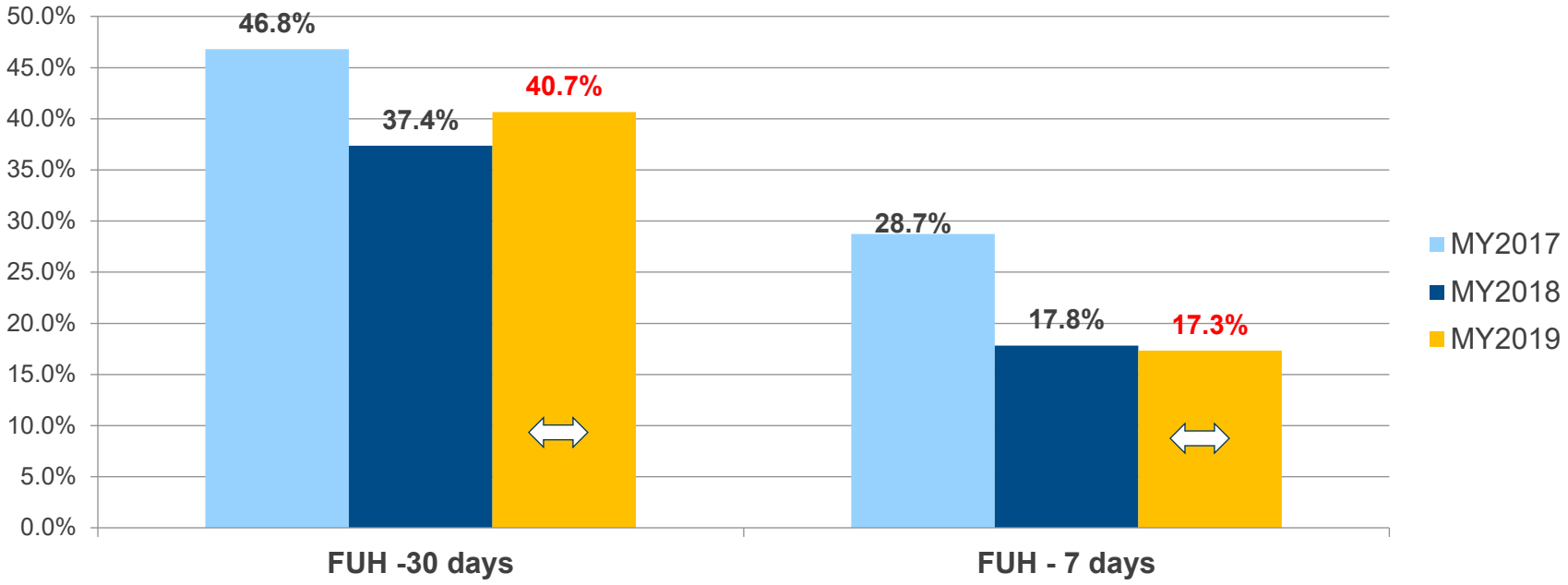
HEDIS 2020 Results: OCC Behavioral Health



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	46.16%	59.74%	71.43%	56.00%	CMS, Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++	24.79%	34.33%	45.62%	18.20%	CMS

*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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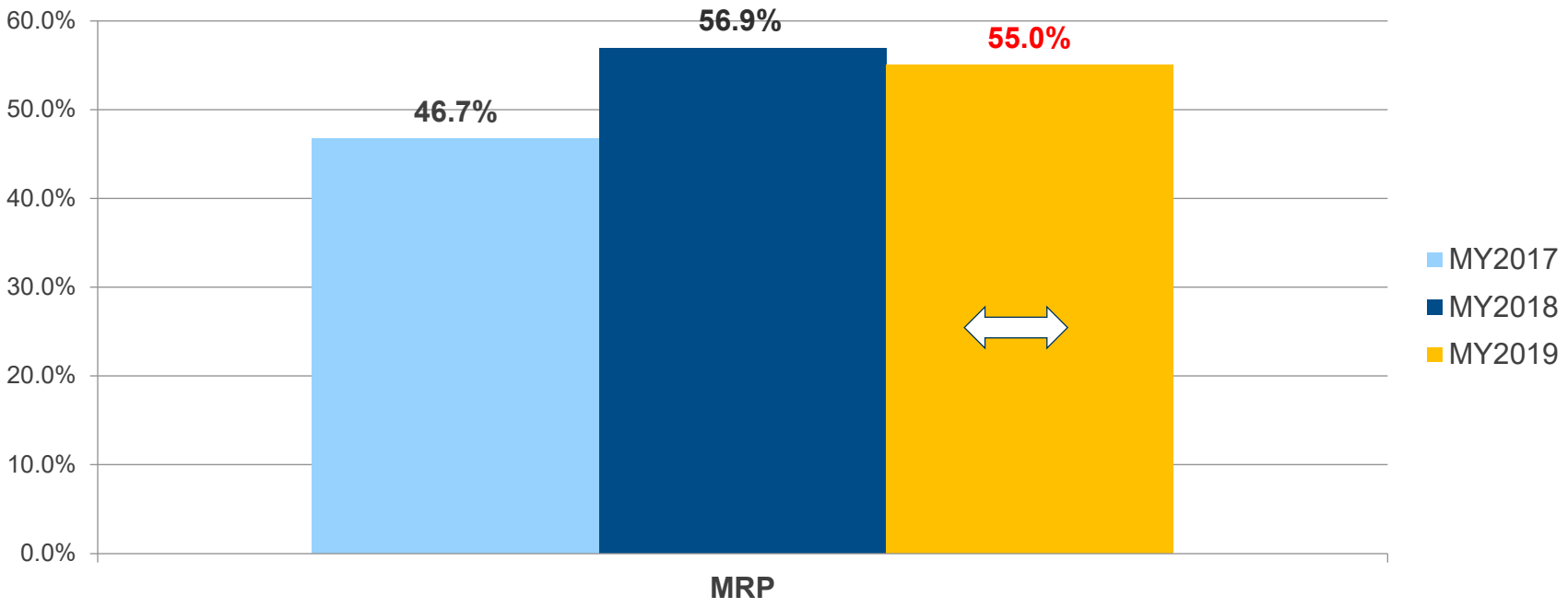
HEDIS 2020 Results: OCC Medication Reconciliation Management



HEDIS Measure	3-Star	4-Star	5-Star	Goal	Reporting Requirements*
Medication Reconciliation Post-Discharge (MRP)	62%	71%	84%	62%	RS, 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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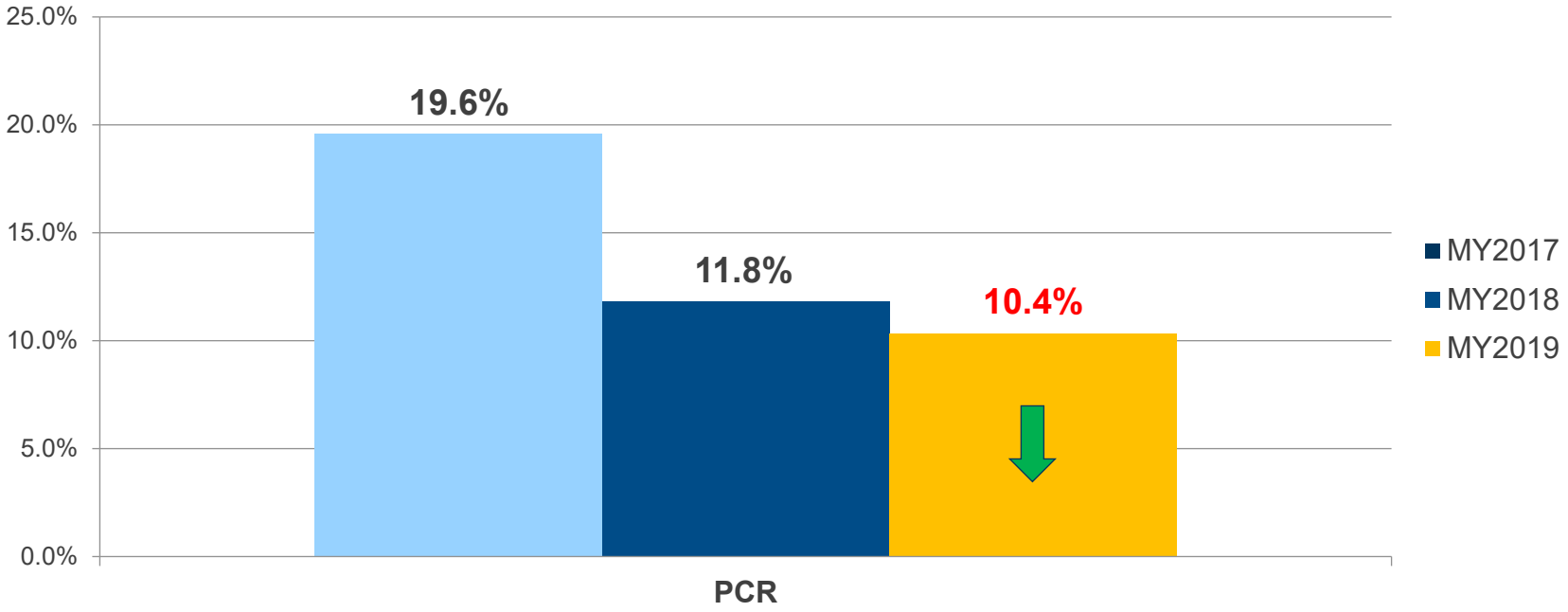
HEDIS 2020 Results: OCC
Plan All-Cause Readmissions — 65+



HEDIS Measure	3-Star	4-Star	5-Star	Goal	Reporting Requirements*
Plan All-Cause readmissions - 65+ (PCR)	8%	7%	3%	8%	Star, P4V, RS, Withhold

*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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OneCare Results

Benchmarks: NCQA National Medicare HEDIS MY 2018 Percentile and CMS Medicare 2019 Part C & D Star Ratings Technical Notes 10/01/2019 update

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MY2019 OneCare Measures

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Controlling High-Blood Pressure	75th	75th
Statin Therapy for Patients with Cardiovascular Disease (Therapy)	2 Star	**3 Star**
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	4 Star	4 Star
Comprehensive Diabetes Care - HbA1c Control (<8)	50th	**75th**
Comprehensive Diabetes Care (Blood Pressure Controlled <140/90 mm Hg)	75th	**90th**
Use of Opioids From Multiple Providers (multiple Prescribers)	50th	50th
Transitions of Care (Notification Discharge)	50th	50th
Transitions of Care (Med Reconciliation)	25th	**50th**
Adult BMI Assessment	4 Star	**3 Star**
Breast Cancer Screening	3 Star	3 Star
Care for Older Adults (SNP) - Medication Review	4 Star	4 Star
Care for Older Adults (SNP) - Pain assessment	4 Star	**3 Star**
Comprehensive Diabetes Care (Medical Attention for Nephropathy)	4 Star	**3 Star**
Adults' Access to Preventive/Ambulatory Health Services (age 20-44)	50th	50th

*Green = higher than last year; Red = lower than last year; +C = trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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MY2019 OneCare Measures

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Comprehensive Diabetes Care (HbA1c Testing)	<=10th	**25th**
Statin Therapy for Patients with Diabetes — Therapy	25th	25th
Medication Reconciliation Post-Discharge	2 Star	2 Star
Use of high-risk medications in the elderly (two or more prescriptions)	<=10th	**25th**
Use of Opioids From Multiple Providers (multiple Pharmacies)	25th	25th
Use of Opioids From Multiple Providers (multiple Prescribers and Pharmacies)	<=10th	**25th**
Initiation of Alcohol and Other Drug Dependence Treatment	25th	25th
Engagement of Alcohol and Other Drug Dependence Treatment	<=10th	**25th**
Plan All-Cause readmissions — O/E Ratio 65+ (C21) **+C**	1 Star	**2 Star**

*Green = higher than last year; Red = lower than last year; +C = trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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MY2019 OneCare Measures

	Quality Compass MY2018 Percentiles Met	
	MY 2018	MY 2019
Colorectal Cancer Screening	3 Star	**2 Star**
Care for Older Adults (Functional status assessment)	3 Star	**2 Star**
Comprehensive Diabetes Care (Eye Exam)	4 Star	**2 Star**
Statin Therapy for Patients with Diabetes (Adherence) **+C**	50th	**25th**
Transitions of Care (Receipt Discharge Info)	25th	**<=10th**
Transitions of Care (Engmt after discharge)	50th	**25th**
Adults' Access to Preventive/Ambulatory Health Services (age 45–64)	25th	25th
Adults' Access to Preventive/Ambulatory Health Services (age 65+)	<=10th	<=10th
Adults' Access to Preventive/Ambulatory Health Services (Total)	25th	**<=10th**

*Green = higher than last year; Red = lower than last year; +C = trend with caution due to specification changes per NCQA Highlighted yellow = Break in trending

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Three Year Trended Results (MY 2017–2019)

Benchmarks: NCQA National Medicaid MY 2018 Percentiles

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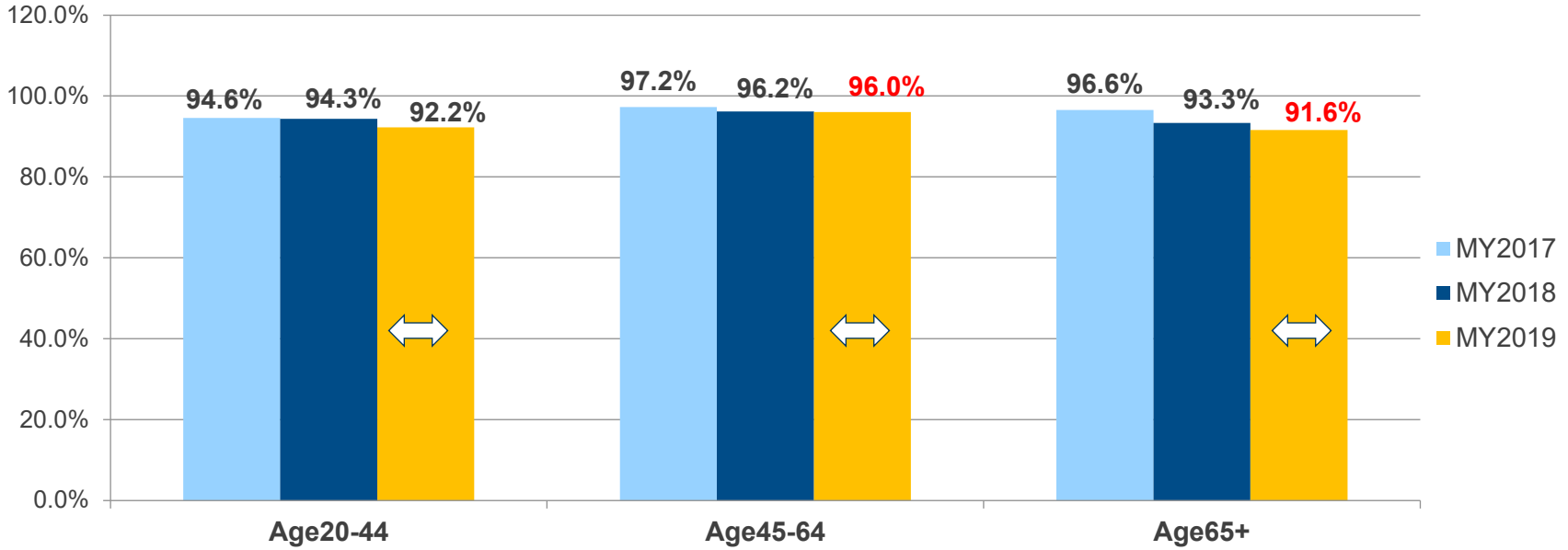
HEDIS 2020 Results: OneCare Annual Visits to PCPs



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Adult's Access to Preventive/Ambulatory Health Services (AAP)					
Age 20–44	92.07%	94.36%	96.52%	94.36%	**CMS**
Age 45–64	96.29%	97.40%	98.56%	96.29%	**CMS**
Age 65+	95.87%	97.12%	98.55%	93.80%	**CMS**

***Red = less than 3-Star or 50th percentile, Green = met the goal**

↑ ↓ statistically higher or lower ↔ statistically no difference

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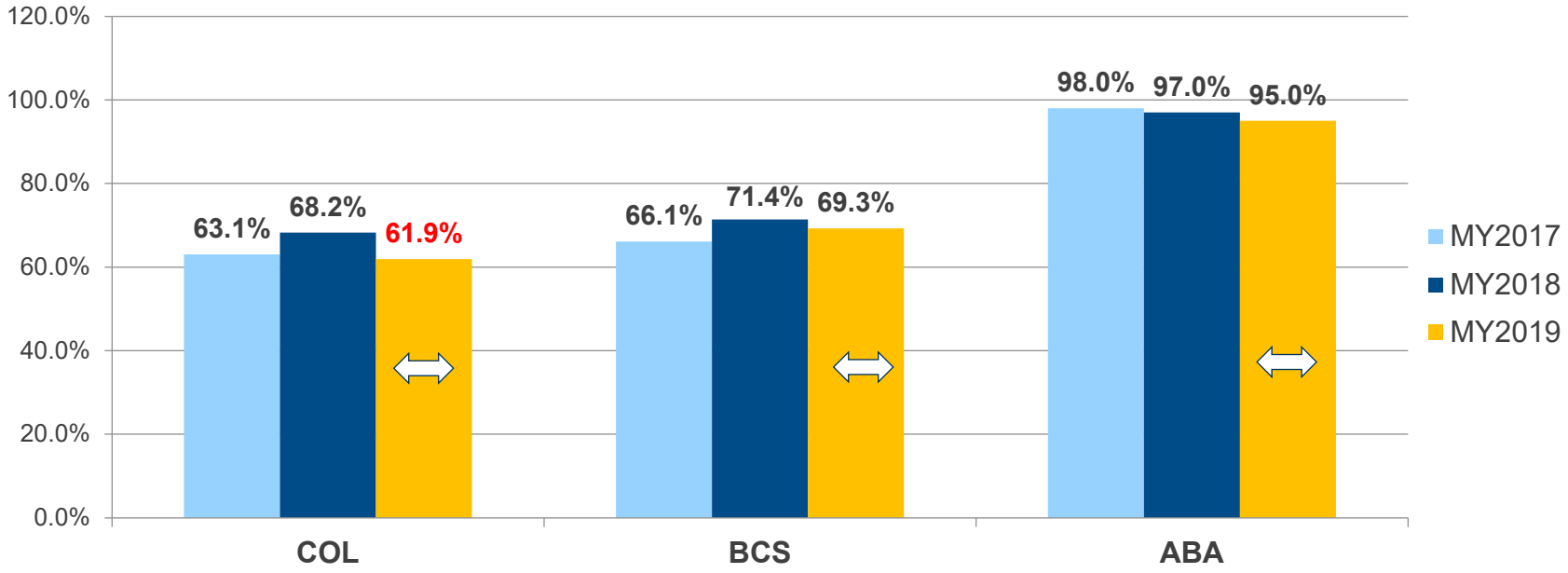
HEDIS 2020 Results: OneCare Prevention and Screening



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Colorectal Cancer Screening (COL)	62%	73%	80%	73%	Star
Breast Cancer Screening (BCS)	66%	76%	83%	76%	Star
Adult BMI Assessment (ABA)	92%	96%	99%	99%	Star

*Red = less than 3-Star or 50th percentile, Green = met the 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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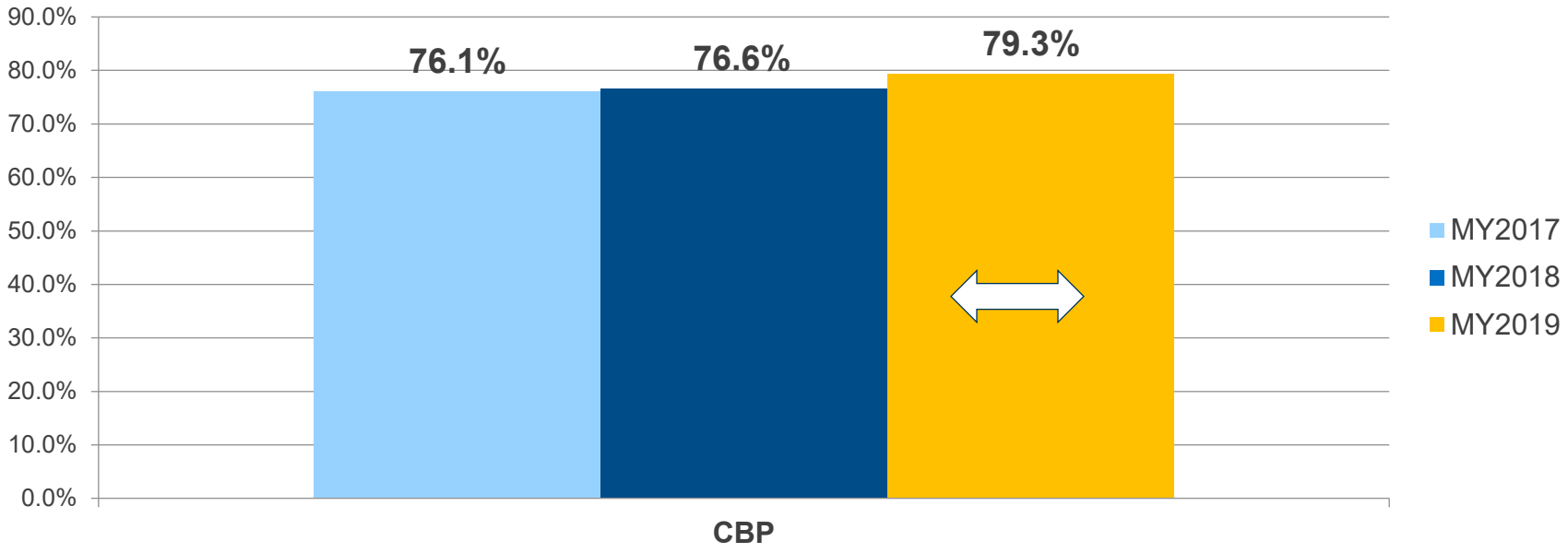
HEDIS 2020 Results: OneCare Controlling Blood Pressure



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Controlling High-Blood Pressure #	70.56%	76.16%	81.27%	78.72%	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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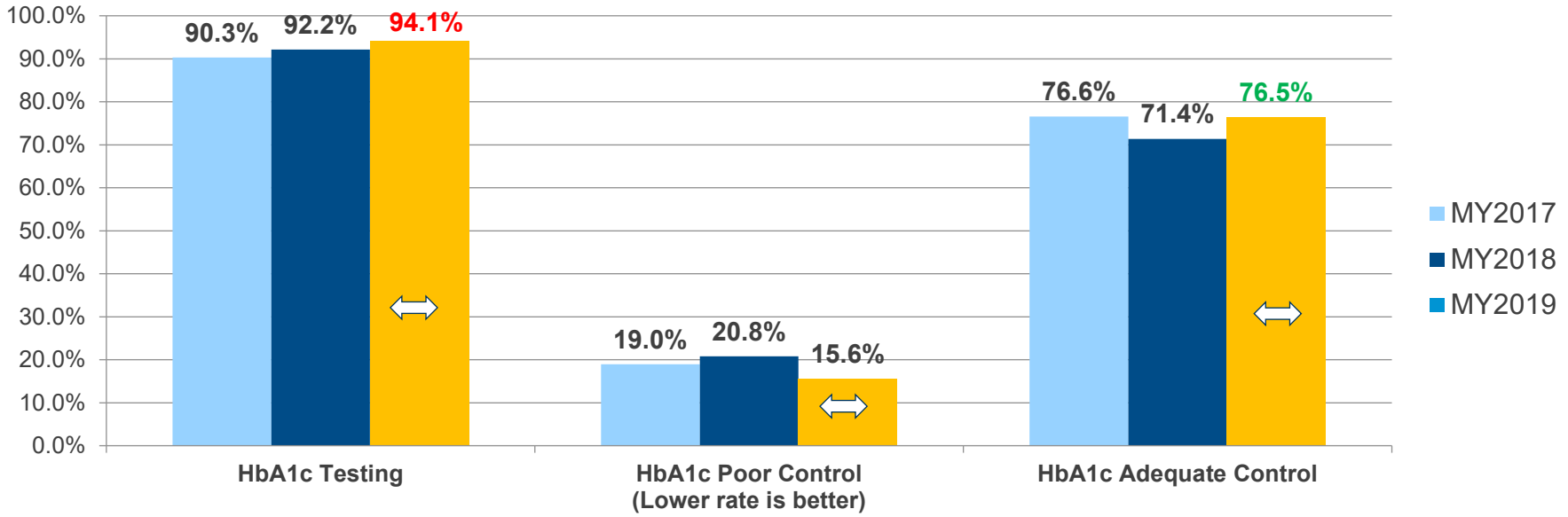
HEDIS 2020 Results: OneCare Comprehensive Diabetes Care — HbA1c



HEDIS Measure	3-Star/ 50th percentile	4-Star/ 75th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements*
Comprehensive Diabetes Care (CDC) — HbA1c Testing	94.89%	96.38%	97.32%	93.00%	CMS
Comprehensive Diabetes Care (CDC) — HbA1c Poor Control (>9.0%) #	39%	28%	15%	15%	Star
Comprehensive Diabetes Care (CDC) — HbA1c Adequate Control (<8.0%)	68.57%	73.57%	77.78%	71.97%	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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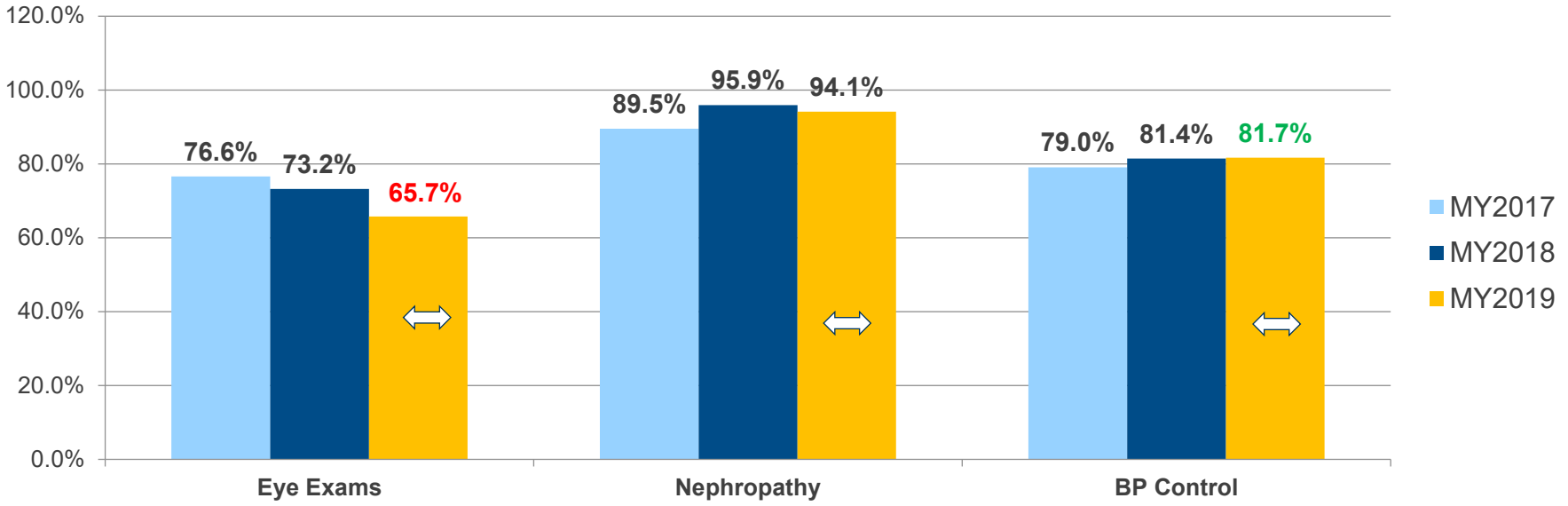
HEDIS 2020 Results: OneCare Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 50th percentile	4-Star/ 75th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements*
Comprehensive Diabetes Care (CDC) — Eye Exams	69%	73%	78%	78%	Star
Comprehensive Diabetes Care (CDC) — Nephropathy Monitoring	80%	95%	97%	97%	Star
Comprehensive Diabetes Care (CDC) — BP Control (<140/90)	69.53%	76.56%	81.50%	81.50%	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

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↑ ↓ statistically higher or lower ↔ statistically no difference

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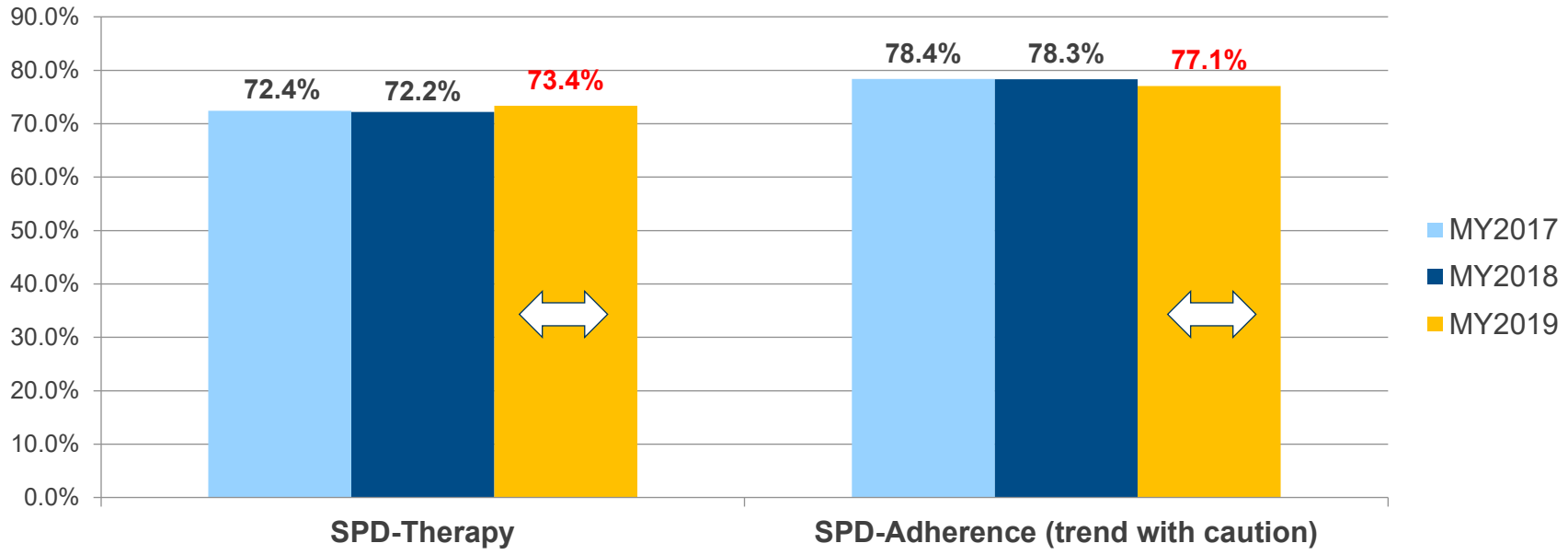
HEDIS 2020 Results: OneCare Diabetes Conditions



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) - therapy	74.13%	77.43%	80.99%	74.13%	CMS
Statin Therapy for Patients with Diabetes (SPD) - adherence	78.03%	81.82%	86.13%	80.27%	CMS

*Red = less than 3-Star or 50th percentile, Green = met goal

↑ ↓ statistically higher or lower ↔ statistically no difference

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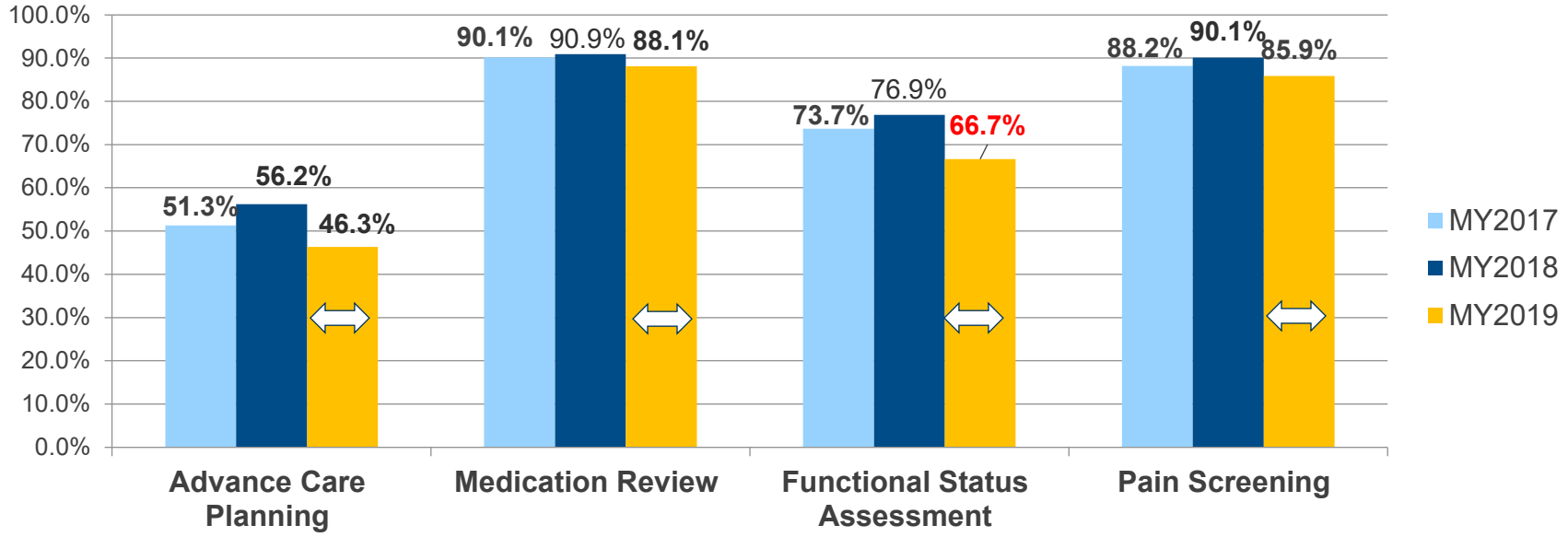
HEDIS 2020 Results: OneCare Care for Older Adults



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements*
Care for Older Adults (COA)					
1. Advance Care Planning	No benchmarks				CMS
2. Medication Review	77%	87%	95%	95%	Star
3. Functional Status Assessment	71%	85%	93%	85%	Star
4. Pain Screening	81%	86%	94%	94%	Star

***Red = less than 3-Star or 50th percentile** **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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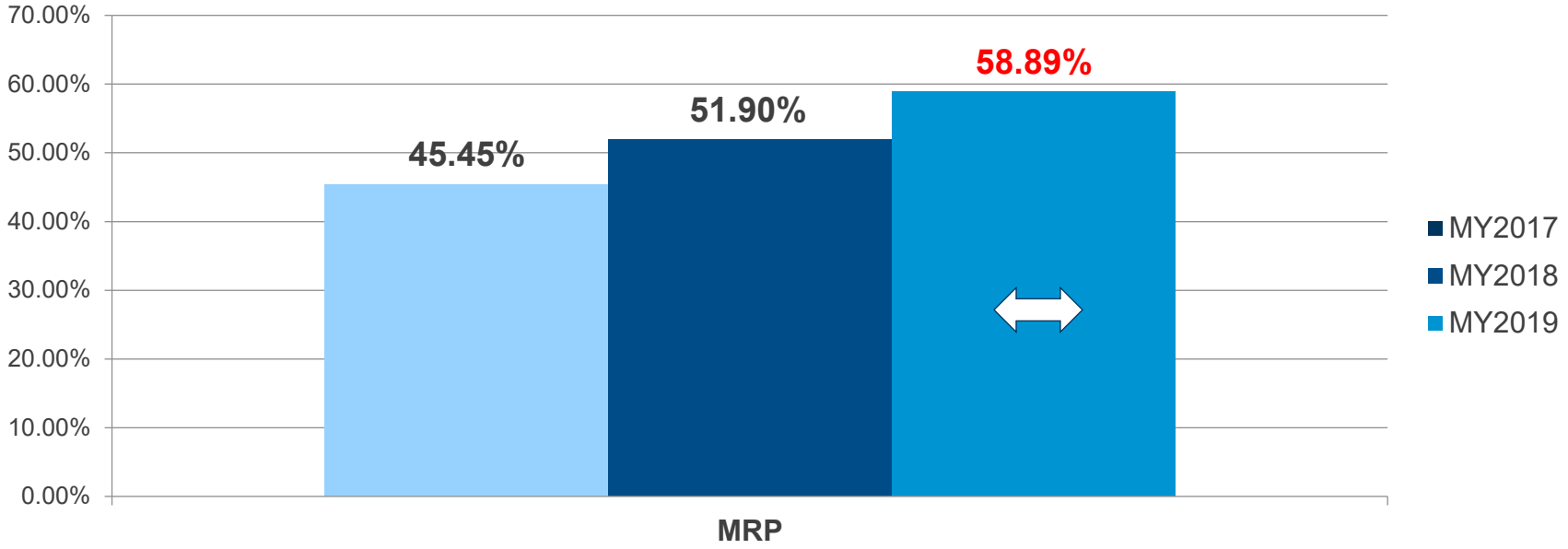
HEDIS 2020 Results: OneCare Medication Reconciliation Management



HEDIS Measure	3-Star	4-Star	5-Star	Goal	Reporting Requirements*
Medication Reconciliation Post-Discharge (MRP)	62%	71%	84%	62%	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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Member Experience (CAHPS)

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Adult Survey Overview

- Sample Size: 1,350
- Fielding Period: February–May 2020
- Response Rate: 19.6%
- Selected Adult Survey for NCQA Accreditation Scoring
  - Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist all achieved lower performance than last year (lower percentile achievement)
  - Rating of Health Plan is double weighted; our score is still at 25th percentile
  - No percentile change for the other measures

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Adult Survey Overview (cont.)

- Results (%) improved from last year but not statistically significant
- Pain points which keep us low scoring
  - Getting Needed Care
  - Getting Care Quickly
- Due to COVID-19 pandemic, trends in scores should be viewed with caution

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Child Survey Overview

- Sample Size: 1,650
- Fielding Period: February–May 2020
- Response Rate: 20.0%
- Results (%) have declined from last year but not statistically significant
- Pain points which keep us low scoring:
  - Getting Needed Care
  - Getting Care Quickly
- Due to COVID-19 pandemic, trends in scores should be viewed with caution

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Next Steps

- Present results to stakeholder groups and committees
- Calculate P4V scores and payments
- Implement strategies on low performing areas
  - Deeper dive into key measures with significant drop in performance (Lead testing, Asthma treatment, others)
  - Priority areas will include low areas of performance and areas related to strategic initiatives (New DHCS MPL measures, NCQA Accreditation, NCQA Health Plan Rating)
  - Analyze select measures for health disparities; use this insight to inform the next Quality Improvement Work Plan

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Intergovernmental Transfer Overview

Quality Assurance Committee Meeting
September 16, 2020

Candice Gomez, Executive Director, Program Implementation

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Intergovernmental Transfer (IGT)

- Background
- Funding Process and Partners
- CalOptima Total to Date
- Funded Projects
- COVID-19 Impact
- IGT 10 Status

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IGT Background

- CalOptima has participated in the Department of Health Care Services (DHCS) annual Rate Range IGT since 2010
- IGTs enable CalOptima and our governmental funding partners to receive additional revenue for services to Medi-Cal members
- IGT processes secure additional federal revenue to increase California's Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services to existing Medi-Cal members
  - IGTs 8–10: Funds must be used for Medi-Cal covered services included in CalOptima's DHCS contract for Medi-Cal members

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IGT Background (cont.)

- Contributions from eligible community funding partners can be matched through the IGT process up to upper rate range as established by the state's actuaries
- No guarantee of future availability of IGT funds
  - Best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries
- Board-approved spending plans are in place for IGTs 1–9

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IGT Funding Process

High-Level Steps:
1. CalOptima receives DHCS notice announcing IGT opportunity.
2. CalOptima secures funding partnership commitments.
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts.
4. Funding partners wire their contribution amount and additional 20% fee to DHCS.
5. CMS provides matching funds to DHCS.
6. DHCS sends total amount to CalOptima.
7. From the total amount, CalOptima returns each funding partner's original contribution.
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and, where applicable, retained amount for Managed Care Organization tax (IGT 1–6 only).
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees.

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Current IGT Funding Partners

- Children and Families Commission of Orange County
- Orange County Health Care Agency
- Orange Fire Department
- Newport Beach Fire Department
- University of California, Irvine

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CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic) March 2016 (MCE)**
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9	$43.96 million	April 2020
IGT 10*	TBD	TBD
Total Received	**$165.27 million**	

- Estimate; Pending DHCS Guidance ** Medi-Cal Expansion
- Determining unspent funds on closed projects is in progress

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IGT 1-7 Funded Projects

- Funds are available to provide enhanced benefits to existing Medi-Cal members
- Project examples include:
  - Internal initiatives
    - Personal Care Coordinators, member and provider portal, depression screenings, etc.
  - Recuperative care and medical respite services
  - Expand safety net services to support clinics to become Federally Qualified Health Centers
  - Community grants
    - Outpatient mental health services for children, integrate mental health into primary care, medication assistance treatment services, dental services, social determinants of health and food distribution
- Unused funds from closed initiatives may be reallocated by the board to other qualifying enhanced services

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IGT 8-9 Funded Projects

- Funds must be used for CalOptima Medi-Cal covered services for our Medi-Cal members, with any expenditures not qualifying as medical expenses counted by the state as part of CalOptima's administrative expenses
- Project examples include:
  - Expanded Office Hours for Member Access
  - Homeless Response Team
  - Hospital Data Exchange
  - Post Acute-Infection Prevention Quality Initiative

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IGT 5-7 COVID-19 Impacts

- Staff met with grantees to discuss impacts to their organization and grant deliverables
  - Heavily relying on virtual platforms, halt/decrease in routine care and increase in food and mental health services
  - On June 4, 2020, the Board of Directors approved
    - Eight requests for no-cost extension
    - Three requests for budget line item revisions
    - Two requests for temporary modifications in scope of work
  - Targeting submission of an additional no cost extension at the September 3, 2020, Board of Directors meeting

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IGT 10 Status

- On February 6, 2020, the Board of Directors approved CalOptima's pursuit of IGT 10 funding
  - Unlike prior IGTs, IGT 10 will cover an 18-month period
    - Rating period July 1, 2019–June 30, 2020 and July 1–December 31, 2020
    - Due to DHCS transition from fiscal to calendar year budget cycle
- Funder's contributions are estimated to be $78.6 million*
  - Funders must return final signed agreements to DHCS by September 2020
  - Two separate DHCS wire transfer requests anticipated between April–September 2021
- CalOptima's share is estimated to be $66 million*
  - CalOptima may receive funds after each rating period wire transfer

* Amounts may change based on actual enrollment and member mix.

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IGT 10 Next Steps

- Identify potential focus areas and initiatives
  - Consider member needs, opportunities to enhance Medi-Cal programs and supporting providers
  - Ensure alignment with 2020–2022 Strategic Plan identified priorities and objectives
- Engage stakeholders proposed allocation of IGT 10 funds
- Present final recommendations to the Board of Directors

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Impact of COVID-19 on Population Health Management

Board of Directors' Quality Assurance Committee
September 16,2020

Pshyra Jones, Director, Population Health Management

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Population Health Management

- **Outreach to emerging risk populations**
  - Bright Steps Maternity Management Program
    - Including “You are Not Alone” First 5 OC Coronavirus pamphlet in CalOptima Bright Steps weekly mailings
    - Informing Bright Steps participants about changes to hospital labor and delivery protocols
    - Screen everyone who comes and goes, allow one additional person plus delivering mom in delivery room, and require wearing a mask, etc.
  - Chronic Conditions
    - Modified scripts for members with asthma, diabetes and COPD to educate COVID-19 prevention strategies and offering CalOptima assistance with medication refills, medical equipment or community resources

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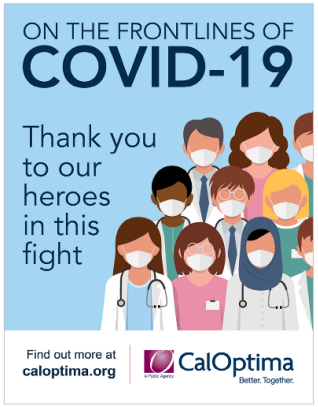
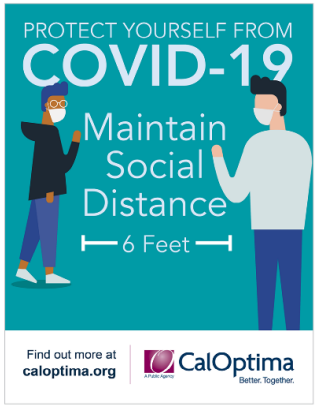
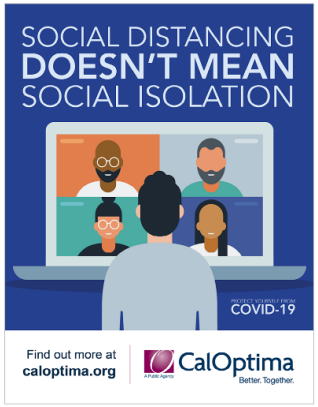
Population Health Management (cont.)

- COVID-19 Community Awareness Campaign







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Population Health Management (cont.)

- Public service announcements to support CalOptima vulnerable populations impacted by COVID-19
  - Taking Care of Your Emotional Health
  - Maternal Mental Health
  - Continuing Prenatal Care
  - Healthy Nutrition and Activity
  - Chronic condition management and support with medications
- Virtual community classes and events
  - Shape Your Life Childhood Obesity Classes –ongoing
  - Community Partners:
    - Latino Health Access
    - Dr. Riba's Health Club

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Population Health Management (cont.)

- Great American Smokeout®: “Escape the Vape” — Nov 19, 2020
  - Community event created to prevent vaping in school-aged children
  - Lead Organizations Include:
    - American Cancer Society
    - CalOptima
    - Orange County Department of Education
    - Orange County Health Care Agency
    - Orange County Tobacco and Vape Free Coalition
  - Event Activities Include:
    - Anti-vaping presentations (prizes for 1st, 2nd, and 3rd places winners)
    - Interviews with the Lost Chord Club

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Questions

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Board of Directors' Quality Assurance Committee Meeting
September 16, 2020

Program of All-Inclusive Care for the Elderly Member Advisory Committee
Second and Third Quarter 2020 -- Updates

Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee (MAC)
PMAC Second and Third Quarter 2020 Updates

The PACE Member Advisory Committee meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima PACE leadership on the PACE care delivery system. The committee is comprised of primarily PACE participants. The second quarter meeting was scheduled for April 2020 and the third quarter meeting was scheduled for July 2020.

As a result of the COVID-19 public health emergency, conducting in-person meetings with PACE participants is not recommended. While virtual meeting options were explored, committee members were found to not have the technical capabilities to engage in virtual conferencing. As a result, the meetings have been postponed until in-person meetings are recommended with infection control precautions or a virtual solution can be implemented.

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Board of Directors' Quality Assurance Committee Meeting
September 16, 2020

Quality Improvement Committee Second Quarter 2020 -- Update

Summary

- Quality Improvement Committee (QIC) met on April 21, 2020, May 12, 2020 and June 6, 2020.
- The following subcommittees reported to QIC in Quarter 2 (Q2):
  - Whole-Child Model Clinical Advisory Committee (WCM CAC)
  - Utilization Management Committee (UMC)
  - Credentialing and Peer Review Committee (CPRC)
  - Member Experience Committee (MEMX)
  - Grievance & Appeals Resolution Services Committee (GARS)
  - Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PACE QIC)
- Accepted and filed minutes from the following committees and subcommittees:
  - UMC meeting minutes: February 27, 2020
  - MEMX meeting minutes: April 15, 2020
  - GARS meeting minutes: November 21, 2019 and February 26, 2020
  - PACE QIC meeting minutes: January 27, 2020 and February 25, 2020; PACE QIC Quarter 1 (Q1) 2020 Update Summary
  - 2019 UM Program Evaluation
  - 2020 UM Program
  - 2020 Quality Improvement (QI) Work Plan Q1

QIC Highlights

- **Quality Program Highlights**
  - National Committee for Quality Assurance (NCQA) Accreditation renewal survey preparations underway. Completed year one of two years in preparation for submission in May 2021. Coronavirus Disease 2019 (COVID-19) accommodations by NCQA have extended a grace period for annual requirements, such as analysis, communications and delegation oversight. They have also extended a grace period for re-credentialing files, as well as removing files from March–September 2020 time frame due to COVID-19.
  - COVID-19 updates were presented at each monthly QIC meeting including Orange County Health Care Agency (OC HCA) reports and updates as well as member-related statistics. Health networks (HNs) shared their experience with testing sites, as well as communications related to countywide collaborations.

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- Telehealth usage and clinical guidance: Due to COVID-19, CalOptima has seen significate increases in the use of telehealth; however, there has been an increase in quality issues due to a lack of documentation of member exams, specifically for PCP referrals to specialists. Also, some documentation appears to be a cut and pasted from the member's previous visit, making it difficult to determine if a recent exam had been performed. It was recommended that records be reviewed, and documentation of the new exam be noted when a referral is generated. A HN medical director shared that they hosted a webinar by the Centers for Disease Control and Prevention (CDC) that emphasized appropriate use of codes and practices during a health visit and recommended it to others.
- Homeless Health Clinical Analysis updates were presented quarterly to QIC, including CalOptima's Homeless Population Clinical Report Card that monitors key performance measures such as enrollment, utilization and medical diagnoses for this vulnerable population.
- Pay for Value (P4V) 2020 Program incorporates an HN Quality Rating (HNQR) approved by the CalOptima Board of Directors (BOD) on March 5, 2020. The HN incentive payments are determined by this rating. No incentive payment is earned if the HNQR rating is below 2.5, and improvement plans are required. P4V per member per month (PMPM) for Medi-Cal will be increased from $2 to $5 PMPM, with payments made annually.

- **UMC**
  - As of November 2019, CalOptima membership remained flat.
  - Fourth quarter Q4 operational performance for medical authorizations is on track, except for one HN. Audit & Oversight (A&O) issued a corrective action plan to that specific HN. Unused authorizations are being reviewed. Current performance for HN average 49.5%. UM is taking a deeper dive into the components of over and under (over/under) utilization.
  - The over/under utilization ad-hoc team met to review first quarter Q1 data, re-energizing the process by looking at other measures within QI, UM, Fraud, Waste and Abuse (FWA), and Potential Quality Issues (PQI). The ad-hoc team will create a dashboard and present it at a future UMC meetings.
  - Utilization outcomes:
    - Medi-Cal outcomes for bed days, readmissions and emergency (ED) visits are at or below the goals.
    - OneCare Connect (OCC) average length of stay (ALOS) and readmissions are at the goals. Bed days and ED visits are approaching the goals.
  - Criteria for clinical decision-making was reviewed and approved by UMC.
  - Pharmacy Management presented a report regarding Statin Therapy for patients with Cardiovascular Disease (SPC) and Statin Therapy for Patients with

Diabetes (SPD), which are above Healthcare Effectiveness Data and Information Set (HEDIS) measure goal for 2020 prospective rates. Persistence of Beta-Blocker Treatment after Heart Attack (PBH) consistently performs below its goal. A new intervention will be initiated to help achieve that goal.

- Medi-Cal Pharmacy Overutilization Monitoring
  - Achieved the goal set in 2018 for Average Morphine Milligram Equivalent (MME). Interventions are in place to reduce overutilization, such as prescriber restrictions, pharmacy home and Polypharmacy Profile reviews.
- The 2019 UM Evaluation and 2020 UM Program were presented and approved at 4/21/20 QIC committee.

- **GARS**
  - Medi-Cal complaints for fourth quarter 4 (Q4) 2019 are similar to previous quarters in 2019. Provider appeals had a 15% increase due to payment requests for high-cost items with inpatient services. Access issues continue to be related to appointment availability and specialty care. GARS is working closely with Provider Relations to help members obtain appointments sooner.
    - Quality of Service (QOS) grievances continue to be the highest category of grievances. In Q4, several QOS grievances were tied to non-medical transportation services, specific to a vendor. The vendor was notified, and action was taken to address the grievance issues.
    - There was a significant decrease in Behavioral Health (BH) appeals, which can be attributed to Department of Health Care Service (DHCS) modification in the authorization review and approval process.
  - OCC saw a slight increase in member and provider appeals. The top issue was related to delay in obtaining durable medical equipment (DME) supplies.
  - In the first quarter of Q1 2020 (Q1) , there was an overall decrease of Medi-Cal complaints by 15%. The top three grievance reasons remain the same as in 2019: Quality of Service, Access, and Quality of Care (QOC).
  - At the end of Q1, COVID-19 related grievances were analyzed by an ad-hoc workgroup and presented to the committee. Members had many questions and concerns related to testing as well as delay in care due to COVID-19. The ad-hoc committee included Customer Service, GARS, QI, and Provider Relations, and collaborated on education, message, and resources to meet member expectations.

- **Behavioral Health Integration (BHI)**
  - Adverse Childhood Experiences (ACEs) Aware Update: a new DHCS policy, All Plan Letter (APL) 20-008 was issued in April 2020 to mitigate health impacts of secondary stress due to COVID-19. The new policy supports

integration of medical and BH services via telehealth, as well as strong care coordination and service linkage with providers on disaster-responsive, trauma-informed care.

- CalOptima continues to collaborate with county BH and Be Well OC to gather resources to address mental health challenges for county residents and front-line providers.
- HEDIS measures:
  - Antidepressant Medication Management (AMM): BHI continues their efforts to educate providers and members on the importance of follow-up appointments through newsletters and outreach to increase follow-up appointments for Pharmacy management associated with an AMM treatment plan, and to track the number of educational events on depression screening and treatment. However, 50% of Members using antidepressants do not have an active intervention. BHI continues to look at the impact of AMM from a depression screening and follow-up (DSF) perspective.
  - Follow Up After Hospitalization (FUH): This area continues to be a challenge. BH directors met with three high volume hospitals to educate them on OneCare (OC) and OCC BH transition and the new inpatient psychiatric admission process. CalOptima is working with OC HCA to ensure county claims are being processed to fully capture all follow-up care data. Next steps are to develop a Guiding Care script to identify members who did not attend their follow-up appointment within 7 days of discharge.
  - Attention Deficit Disorder (ADD): Follow-up care for children with prescribed Attention Deficit/Hyperactivity Disorder (ADHD) medication has a pharmacy intervention of a 30-day limit on initial prescription fill to encourage members to attend a follow-up appointment with their provider. However, due to the pharmacy carve-out effective January 1, ,2021, and limited BHI resources, the team has been exploring alternative interventions.
  - Depression Screening and Follow-up (DSF) Staff is working with IS to develop a report based on patient health questionnaire (PHQ) scores. Once data is available, will be tracking follow-up appointments for members who scored positive.

- **Population Health Management (PHM)**
  - Post-Acute Infection Prevention Quality Incentive (PIPQI) is a patient safety PHM program aimed at fighting Multi-Drug-Resistant Organisms (MDRO) in residential facilities. MDRO is highly sensitive to chlorhexidine, an antiseptic that fights bacteria that is used to clean the skin to prevent infection that may be

caused by surgery, injection or skin injury. It is also being used to fight COVID-19 related infections. The CalOptima BOD approved a $3.4 million infection prevention program expansion, including an additional $7,500 quarterly incentive. These incentives will be distributed to PIPQI facilities to help offset implementation costs.

- Homeless Clinical Access Program (HCAP) focuses on increasing access to preventive care for individuals experiencing homelessness through mobile clinics. In August 2019, the BOD approved a two-tier quality incentive program with additional program components that were approved in April 2020. The expanded HCAP components support telehealth visits and Clinical Field Teams (CFT). CalOptima has expanded the Tier 1 quality incentive to CFTs to support extended availability and on-call services.

- **Whole Child Model — Clinical Advisory Committee (WCM CAC)**
  - Provided updates from the February 19, 2019, meeting. Although quorum was not met at this meeting, the meeting proceeded without motions. WCM Quality and Reporting measures were presented, which included appeals, inpatient and readmission rates. Continuity of Care (COC)—reference APL 18-023—was also discussed and indicated that members will receive COC with existing California Children's Services (CCS) providers for up to 12 months, which expired July 1, 2020. WCM members/families were notified about the change. After July 1, 2020, requests for extension of continuity of care with out-of-network providers will be evaluated on case by case basis.

- **Member Experience Sub-Committee (MEMX)**
  - Focus on timely access and network adequacy monitoring.
  - Timely access survey, fielded in 2019 with new mystery shopper methodology, identified significant issues related to appointment availability for our members. During the survey, a live contact was reached only 71.7% of the time. Of the live contacts, only 26.2% were able to provide an appointment and 45.5% were not able to provide an appointment. CalOptima's internal benchmark is 80%, and results were lower than previous years, although the data cannot be trended due to a methodology change. The area of focus is urgent and specialty care appointments (e.g., neurology, pulmonology, endocrinology, gastroenterology) and provider data quality. Next steps are to share the results with HNs and dive deeper to address these focus areas.
  - Network Adequacy workgroup has focused on DHCS Annual Network Certification (ANC) and the requirements to meet time and distance standards. Standards require analysis of network adequacy based on "anticipated membership." The "Percent of Census" methodology was approved by DHCS and will be used to anticipate membership going forward. CalOptima met all

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network adequacy requirements and standards at the plan level, and no alternative access standards were requested. For DHCS subcontracted network certification, CalOptima submitted a Plan of Action (POA) to DHCS that provided an overview of CalOptima's distinct direct/subcontracted networks. The POA was approved by DHCS.

- **Credentialing and Peer Review Committee (CPRC)**
  - CPRC reviewed 308 initial and recredentialing CCN practitioner and organization providers (OP) in the first quarter of 2020 (Q1). Credentialing met 100% timeliness for recredentialing files. No medical disciplinary actions were taken. Going forward, this report will include reporting the CalOptima network's credentialing activity to QIC.
  - The Facility Site Review (FSR) team conducted 16 initial and 75 full scope site reviews, and 114 Physical Accessibility Review Surveys (PARS). Three sites failed Medical Record Reviews (MRR). A repeated theme is low documentation scores for adult preventive measures. Corrective Action Plans (CAPs) were issued, and panels closed until the CAPS are closed. Effective April 24, 2020, per APL 20-011, in-person site reviews were temporarily suspended. In addition, the implementation of the new FSR tool from DHCS is on hold due to COVID-19 until further notice. However, the FSR team is evaluating methods to conduct virtual visits or hybrid visits to minimize time spent in the provider office.
  - Potential Quality Issue (PQI) team opened 427 cases in Q1. No QOC issues or service-related issues were determined for 97% of the cases. The 3% of PQI cases were determined to be QOC issues, and appropriate action was taken. The QI department is taking a deeper dive into the cases referred to PQI that have no QOC or service-related issues.

Attachments
2020 Quality Improvement Work Plan Q1

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2020 QI Work Plan 1Q

2020 QI Work Plan Element Description	Goals	Planned Activities	**Staff Responsible**	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.*)	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT						
2020 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2020 QI Program and Workplan by March 2020	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Betsy Ha	Approved: QIC 1/14/20; QAC 2/19/20; BOD 3/5/20		
2019 QI Program Evaluation	Complete Evaluation 2019 QI Program by January 2020	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Betsy Ha	Approved: QIC 1/14/20; QAC 2/19/20; BOD 3/5/20		
2020 UM Program	Obtain Board Approval of 2020 UM Program by June 2020	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Mike Shook	UMC will be taking UM Pgoram to QIC on 4/21/20	UMC will be finalizing the UM Program and will present at the next QIC	
2019 UM Program Evaluation	Complete Evaluation of 2019 UM Program by March 2020	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Mike Shook	UMC will be taking UM Eval to QIC on 4/21/20	UMC will be finalizing the UM Eval and will present to QIC	
Population Health Management Strategy	Review and implement strategy in 2020	Review and adopt on an annual basis	Pshyra Jones	Population Heatlh Management Strategy was written in May of 2019, and presented at QIC in August of 2019. The annual review of the strategy is in progress, and will be presented at QIC in Q2.	Strategy will be presented at QIC in Q2.	
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee, as well as Nursing Facility and CBAS quality oversight annual results.	Miles Masastugu, MD/ Esther Okajima	CPRC reviewed and approved 308 initial and recredentialing CCN files (including Practitioners and OPs) in Q1. There were no disciplinary action/taken or denials of applications. All files met the recredentialing timeliness goal of 36 months. FSR team completed 16 Initial FSR/MRR, and 75 Full scope FSR/MRR. 2 sites were overdue (past 36 months). There were 3 sites that had failed scores which the panels were closed. 70 CAPS were issued. For PARS there were 114 Completed in Q1 of which 41% had Basic access, and 59% had LImited Access. PQI team opened 427 cases, closed 381 PQI's in Q1, 97% were determined no quality of care issue or service related issue. With COVID-19 epedemic, all FSR's were put on hold, however staff is exploring options for virtual FSR's. Staff has conducted several Initial FSR's virtually, however they come with challenges. Staff is also exploring possibility of conducting Periodic FSR's virtually. Will report next quarter on progress. DHCS has postponed implementation of new APL and corresponding tools.	Share learnings from virtual FSR (Initial and Periodic), and results from new webapp that went live 5/1/2020.	
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Mike Shook	UMC reported to QIC 1/14/20. QIC accepted and filed 11/21/19 UMC Meeting minutes that included P&T Committee minutes from 5/16/19 and BMSC 8/28/19 Meeting Minutes. QIC accepted and filed.	UMC will report next on 4/21/20 and bring the 2019 UM Eval and 2020 UM Program.	

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Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Kelly Rex-Kimmet/Marsha Choo	MEMX reported to QIC 3/10/20. Rreported an amended contract with SullivanLuallin and continued promotion of provider coaching and workshops to improve customer service. That information has been shared at several Health Network and Quality Forums. Member Experience continues to work with DHCS who provides data to perform Provider data validation and are adding "Urgent Care" services to be at the forefront of the directory for easy access to members. Three CalOptima Days where held in Q4. Member Experience is restructured access workgroups reporting to Member Experience Sub-committee: 1) Timely Access / Accessibility 2)Network Adequacy / Availability.MCPs will be required to impose CAPs on subcontracted networks who do not meet Annual Network Certification requirements. The subcontracted network will be required to provide out-of-network access to other providers within the primary MCP Network.	Each MCP must submit a Plan of Action (POA) that will provide an overview of the MCP's distinct subcontracted networks and direct network and address implementation efforts related to the July 2021 subcontracted network certification by March 18, 2020 along with the 2020 Annual Network Certification (ANC) submission.	
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	T.T. Nguyen, MD	WCM met 2/18/20 quorum was not met but meeting proceeded without voting. WCM Dashboard was presented. Charter was discussed. Pharmacy carve out and cost was discussed. Next WCM CAC meeting will be held 5/19/20.		
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Ana Aranda	GARS reported to QIC 1/14/20 3Q results on Medi-Cal Complaints, Medi-Cal Grievances by Category, Overall utilization of Non Medical Transportation grievances, Medi-cal BH Appeals and Grievances, Comlaints. Grievances related to wrong referrals caused by incorrect provider data have been trending down as the Provider Data Initiative continues to improve the collection of provider information. CalOptima continues to review all grievances and appeals for: Trends, Improvements, Corrective Actions.	CalOptima continues to review all grievances and appeals for: Trends, Improvements, Correction. GARS is working with the QI team in identifying these trends for further recommendations and actions.	

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PACE QIC - Quarterly review and update of PACE QIC activities		The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and summarized quarterly at QIC	Miles Masatsugu, MD	PACE QIC reported to QIC 2/11/20. 2019 PACE QI Plan Evaluation & 2020 Pace QI Plan Program Description, PQIC Nov 12, 2019 and PQIC 12/10/2019 meeting summary.	PACE will be reportin to QIC May 12, 2020	
Quality Withold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2020	Monitor and report to QIC	Kelly Rex-Kimmet/ Sandeep Mital	For DY5 (CY2019), CalOptima has successfully passed 7 of the 9 OCC Quality Withhold measures. We are still waiting for final chart review data for one measure (Controlling Blood Pressure - CBP). The only measure we fell short is the Follow up after Hospitalization 30 days: Benchmark = 56: CalOptima rate = 32.65.	We expect to pass the CBP measure goal, which will mean that CalOptima will pass 8 of 9 measures. Our overall pass rate is expected to be 88.88% and health plans get 100% of the withheld amounts if they score 80% or higher.	
Quality Program updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2020	**Varies per measure**. Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Kelly Rex-Kimmet/ Paul Jiang	P4V 2020 Payment COBAR with 2020 MCAS measures and HN quality rating determining incentive payment will be going before CalOptima's QAC o February 20, 2020. Staff will propose to increase P4V PMPM for Medi-Cal from $2 PMPM to $5PMPM. Payment will continue to be annual and no changes to occur for OCC P4V measures. Payments for Measurement Year 2018 were disbursed electronically to Health Network in December 9, 2019 for Medi-Cal and One Care Connect and payment.	Take Incentive Payment to QAC on February 20th. CCN provider payments calculations have been completed. Checks will be mailed to providers in January. Kelly Rex-Kimmett presented. CalOptima Quality Forum will resume March 18, 2020.	
Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIP:** Improving access to Acute to Acute/Preventive Care Services to MC member experiencing Homelessness in OC; Improving well-care visits for children int he 15 months of life (W15) **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% **OCC QIP:** Improving Status Use (SPD) **OCC PIP:** Member with ICP with documented discussions of care goals **PPME (OC):** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC):** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents	Helen Syn/ Mimi Cheung/Sloane Petrillo/ Cathy Osborn	All of the project listed are being monitored quarterly and reviewed by the Population Health, Case Management, and LTSS. Currently the main barrier that exists is internal. Many of the projects need executive sponsor and medical director review. In light of COVID-19 activities, it has been difficult to review and monitor progress. Will be setting up internal/adhoc workgroup to review detailed progress of each quality improvement project. Note: projects tied to specific HEDIS measures are updated within the specific measure. 1. OCC PIP year 2 annual evaluation was submitted 5/1/2020. Both areas, ICP and showed statistically significant improvement. If accepted, this PIP will end. 2. PPME (OC) HRAs and HN MOC Oversight; a. OC- All Health Networks demonstrated a very high level of compliance with file review and bundle return (Jan/Feb/Mar attached). b. OC- HRA For annual reviews, first quarter is showing compliance for outreach and collection. Newly enrolled members show compliance for outreach Jan & Feb. March outreach is still in process and therefore, the completion rate and collection rate is not finalized at this time. 3. QIPE (OCC) HRAS, HN MOC OVERSIGHT, ICP HIGH/LOW RISK, ICP WITHING 90 DAYS. a. OCC-HRA: First quarter exceeded goals for outreach and collection on newly eligible members. Annual outreach exceeded goal; but due to non responders, collection rate did not (1st quarter attached). b. OCC- HN MOC OVERSIGHT: CalOptima implemented a compressed timeframe for OCC bundle return. All files must be returned within 45 days of HRA collection for all members eligible from 1/1/20 forward. This did not impact the January data, as it reflect December. By March, while most networks still achieved a high level of compliance, one network showed a reduction in its level of compliance. As this is a new process, we will monitor and support the network during quarter 2 as they adjust to the new process. (Jan/Feb/Mar attached) c. OCC-ICP High/low risk: The compressed time frame applied to members regardless of risk. The downstream effect is higher % completion rates for ICPs overall and Q1 is the first to see the full impact of this change. Overall, the HNs have responded well to this new expectation. d. OCC-ICP Completed within 90 days of enrollment-CalOptima continues to monitor MMP 3.2 monthly. The positive impact of a compressed timeframe for bundle return implemented 1/1/20 has been dramatic for the 90-day care plan completion rate.	Setup up quarterly reviews with adhoc workgroup consistenting of executive leadership and medical directors to share details and obtain feedback from medical directors.	

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II. QUALITY OF CLINICAL CARE						
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 44.82%; OC 58.82%; OCC 50.39%	Educate providers and members on importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. Track number of educational events on depression screening and treatment.	Edwin Poon	Trend continues to maintain above 50% without an active intervention.	Continue to look at potential impact from DSF.	
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS 2020 Goal:** 30-Days: OC: NA; OCC: 56% 7-Days: OC: NA; OCC: 18.20%	1) Visit top 3 hospitals in the first quarter. 2) Follow up with facilities during regular joint operation meetings. 3) Outreach to members post discharge to coordinate follow-up appointments. 4) Track the number of members that have a follow up appointment at discharge.	Edwin Poon	CalOptima directly managing LOB as of 1/1/2020. Directors met with 3 high volume hospitals to educate on transition and new process. Transition of Care Management (TCM) team building relationships with hospitals; completing script in Guiding Care to document follow-up appointment outreach. CalOptima working with OC HCA to ensure that all County claims are being processed to fully capture all data.	Develop report to pull Guiding Care script data. Establish tracking method identify members that did not attend follow-up appointment with 7 days of discharge.	
Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)	**HEDIS 2020 Goal:** SPC - Therapy MC 77.57%; OC 79%; OCC 79% SPD - Therapy MC 70.19%; OC 74.13%; OCC 74.13%	1) Quarterly faxes to Provider offices with lists of members missing an appropriate statin (SPD: any potency statin; SPC: moderate to high potency statin) or members who fall below adherence thresholds (PDC< 80%). (Rx) 2) SPD targeted mailings to members based on list provided from Pharmacy Provider outreach. (PHM) 3) Conduct IVR outreach calls to targeted members. (PHM) 4) Track the number of new members starting appropriate statins medications from targeted outreach list. 5) Track the number of members who were adherent to appropriate statins using calculated PDC rates.	Nicki Ghazanfarpour/ Helen Syn	1. Provider fax interventions completed by Pharmacy Dept for SPD: 564; Successful: 560; Failed: 4 (faxes); 6,392 (members) Total Mbr Count: MCAL: 5,665; OCC: 663; OC: 64 1. Provider fax interventions completed by Pharmacy Dept for SPC: 262; Successful: 248; Failed: 14 (faxes); 608 (members) Total Mbr Count: MCAL: 490; OCC: 106; OC: 12	1. Pharmacy: Continue Provider fax campaign quarterly. 2. Next Statins member mailing to Medi-Cal, OC and OCC members with diabetes to promote conversation with PCP about whether statins are right to reduce cardiovascular risk to be mailed out in May 2020. Medi-Cal: 1007 OneCare: 8 OneCare Connect: 125	

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Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	**HEDIS 2020 Goal:** MC 77.93%; OC N/A; OCC N/A	1) Quarterly faxes to Provider offices for members missing persistent beta blocker use for a total of 6 months post-ASCVD date. 2) Track the number of members who are persistently using beta blockers 6 months post-ASCVD date.	Nicki Ghazanfarpour	1. Provider fax interventions completed by Pharmacy Dept for PBH: 197; Successful: 186; Failed: 11 (faxes); 383 (members) Total Mbr Count: MCAL: 335; OCC: 47; OC: 1	1. Continue Provider fax campaign quarterly.	
Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	**HEDIS 2020 Goal:** MC 76.07%; OC 95.66%; OCC 93.70%	1) Continue Homeless Clinical Access Program (HCAP) program. This program started in late 2019 and will be available for members in 2020 2) Support health networks and provider offices with targeted outreach (i.e. CalOptima Day activities) 3) Implement the Health Equity PIP to improve access to acute/preventive care services for homeless members. 4) Track the number of homeless members accessing preventive care services at Homeless clinic events, and help transition members back to PCP	Pshyra Jones/ Jasmine Awadallah/ Helen Syn/ Mimi Cheung	Update reported by Helen to QIC on 2/11 - Homeless Clinical Access Program (HCAP) program: Encouraging the use of primary care services rather than urgent services through mobile health clinics **2020 March Prospective Rate (PR):** MC: 36.77% OC: 57.74% OCC: 60.84% Measure is performing better than same time last year for all LOBs (MC, OC, OCC)	HCAP successfully onboarded 5 Community Health Centers and is not accepting Telehealth visits. Additionally, the Tier 1 incentive is being expanded to Clinical Field Team.	
Cervical Cancer Screening (CCS)	**HEDIS 2020 Goal:** MC 63.99%	1) Implement $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach (IVR, call campaigns, etc.)	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1) # of CCS 2020 member incentives processed as of 3/31/20: 52; To be processed as of 3/31/20: 1** Direct mailing is scheduled for end of Q2 **2) 2020 March Prospective Rate (PR):** MC 49.66%. Measure is performing better than same time last year.	Incentive has been promoted to Health Networks, but direct to member incentive mailing is scheduled in June/July 2020. Due to the COVID19 situation, we assume a decline in appointments being scheduled for preventive screenings.	
Colorectal Cancer Screening (COL)	**HEDIS 2020 Goal:** OC 73%; OCC 73%	1) Implement new member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy)	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1) # of COL 2020 member incentives processed as of 3/31/20: 0** Direct mailing is scheduled for end of Q2 **2) 2020 March Prospective Rate (PR):** OC: 42.93% OCC: 42.30% Measure is performing better than same time last year for both OC/OCC.	Incentive has been promoted to Health Networks, but direct to member incentive mailing is scheduled in June 2020. Due to the COVID19 situation, we assume a decline in appointments being scheduled for preventive screenings.	

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Breast Cancer Screening (BCS)	**HEDIS 2020 Goal:** MC 63.98%; OC 76%; OCC 66%	1) Implement $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings. Track the number of calls listened to from targeted outreach campaigns (i.e. IVR or direct phone outreach) 5) Track the number of mammograms scheduled through targeted call campaigns.	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1) # of BCS Medi-Cal 2020 member incentives processed as of 3/31/20: 6; To be processed: 4** No OC or OCC BCS incentives yet have been received. **2) 2020 March Prospective Rate (PR):** MC: 48.89% OC: 55.93% OCC: 51.94% Measure is performing better than same time last year for MC and lower for OC/OCC.	Incentive for all LOBs has been promoted to Health Networks, but direct to member incentive mailing is scheduled in June/July 2020. Due to the COVID19 situation, we assume a decline in appointments being scheduled for preventive screenings.	
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 55.50%	1) Develop CORE report and track the numbers of members that filled Rx and their providers. 2) Coordination for members and providers through outreach and assistance with appointment setting and reminders. 2)Track the number of members that have a follow up appointment scheduled.	Edwin Poon	Continued pharmacy intervention of 30-day limit on initial Rx fill for members to attend a follow-up appointment with provider. CORE report developed to identify members that filled Rx. Interventions only effective through end of the year due to upcoming pharmacy benefit changes. Due to limited resources, unable to conduct member outreach.	Explore resource options for outreach. Look at alternative interventions in preparation for changes to pharmacy benefit.	

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Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS 2020 Goal:** **MC: NA**	1) Develop way to load PHQ scores from Guiding Care to HEDIS software. Develop way to capture information (i.e., PHQ scores and scheduled f/u appt.s) from provider offices. 2) Educate providers on depression screening tools and importance of screening. 3) Educate providers and members on importance of follow up appointments via newsletters/ outreach. 4) Track depression screening scores completed by internal staff in GC. 5) Track number of educational events for depression screening and treatment, and increase # compared to last year.	Edwin Poon	Developed a way to load PHQ scores to HEDIS software from Guiding Care to capture data for reporting. Developing CORE report with IS to pull Guiding Care data for tracking.	Identify other sources of data where depression screenings are being completed. Begin tracking data. Develop a way to identify and load f/u appointments for members that scored positive.	
Well-Care Visits in first 15 months of life (W15)	**HEDIS 2020 Goal:** MC 65.83%	1) Implement CalOptima Days targeting the W15 population only and track the number of members who engaged in W15 CalOptima Day events. 2) Implement **Member** incentive program for completing 1-3 and 4-6 well-child visits in the first 15 months of life and Track the number of W15 incentives paid out to members 3) Implement **Provider** incentive program for the W15 measures; members must complete 1-3 and 4-6 visits. Track the number of W15 incentives paid out to providers.	Pshyra Jones/ Helen Syn/ Mimi Cheung	At QIC 2/11/20 Helen reported: Root cause analysis is being performed to ensure data is correct and children are accessing the services. Currently working with two high volume provider offices to launch a more conservative efforts **1) # of W15 1-3 and 4-6 visit 2020 member incentives processed as of 3/31/20: 133: To be processed: 88** Member: Provider (2019) Focused Pilot: **166 approved, 106 denied** ; closed out Provider (2020): Pending close out of all Q1 incentives **2) 2020 March Prospective Rate (PR):** (W15 all 6 visits) MC 13.42% Measure is performing lower than same time last year.	Incentive has been promoted to Health Networks, but direct to member incentive mailing is scheduled in June/July 2020. Due to the COVID19 situation, we assume a decline in what members may perceive as non-urgent appointments. Telehealth visits being promoted for well child visits. Efforts to promote outreach and incentives at key offices have been discussed with CHOC, AltaMed, Noble, Monarch and individual high volume provider offices. Health Network Quality collaboration will continue on W15 as well as other HEDIS measures. Provider communications to be sent via Provider Update and other Health Network communications for further clarification. CalOptima Member Incentive posters to be distributed to health networks and individual sites.	
Adolescent Well-Care Visits (AWC)	**HEDIS 2020 Goal:** MC 60.34%	1) Implement $25 member incentive program for adolescents 12-17 years old and Track the number of AWC incentives paid out to members. 2) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events.	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1) # of AWC 2020 member incentives processed as of 3/31/20: 436; To be processed; 535** CHOC promoted member incentives to CHOC network providers which created thrust of majority of submissions for new Adolescent Well Care incentive. **2) AWC 2020 March Prospective Rate (PR):** MC: 9.05% Measure is performing better than same time last year.	Incentive has been promoted to Health Networks, but direct to member incentive mailing is scheduled in June/July 2020. Due to the COVID19 situation, we assume a decline in what members may perceive as non-urgent appointments. Telehealth visits being promoted for postpartum visits. Health Guide for members ages 13-17 to be mailed in June with AWC incentive. The relatively higher number of incentives being sent it is due to provider offices submitting visits. With the promotion of incentives to Health Networks, many more incentives are being submitted by providers than previous years where members mailed or initiated submission. It has been communicated to submitting provider offices, that incentives are to be used to promote future utilization for historical non-compliant, rather than solely to award past utilization. However, there may be a benefit for rewarding members for utilization to reinforce future behavior as well.	

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Children and Adolescents' Access to Primary Care Practitioners (CAP)	**HEDIS 2020 Goal:** **MC:** 12-24 Months 95.62% 25 months-6 years: 87.87% 7-11 years: 92.33% 12-19 years: 90.21%	1) Targeted outreach campaigns (IVR, call campaigns, etc.) 2) Also see other measure activities: [W15, AWC, IMA, CIS activities] 3) Track number of members who have an office visit after targeted outreach campaigns (i.e. IVR/Text messaging) 4) CAP measures is impacted by the following measures: W15, AWC, IMA, CIS and it's activities.	Pshyra Jones/ Helen Syn/ Mimi Cheung	**Child Access to Primary Care (CAP)** **2020 March Prospective Rate (PR) Medi-Cal:** 1. Age 12 - 24 months: 82.47% 2. Age 25 months - 6 years: 47.04% 3. Age 7- 11 years: 76.50% 4. Age 12 - 19 years: 74.16% Measure is performing better than same time last year for all submeasures.	Measure is impacted by other measure interventions (W15, AWC) Health Guide for members ages 13-17 to be mailed in June with AWC incentive. Telehealth visits are being promoted during the COVID19 quarantine.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing	**HEDIS 2020 Goal:** MC: HbA1c Testing: 89.78% OC: HbA1c Testing: 93% OCC: HbA1c Testing: 93%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out	Pshyra Jones/ Helen Syn/ Mimi Cheung	**CDC A1c:** **1) # of A1c Testing - 2020 member incentives processed as of 3/31/20: 0; To be processed: 4** Direct mailing to all members with diabetes scheduled for June 2020. **2020 March Prospective Rate (PR):** MC: 43.25% OC: 39.34% OCC: 46.77% Measure is performing better than same time last year for MC and OCC and lower for OC	Incentive for all LOBs has been promoted to Health Networks, but direct to member incentive mailing is scheduled in June/July 2020. Due to the COVID19 situation, we assume a decline in appointments being scheduled for routine visits or lab work.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Good Control (<8.0%)	**HEDIS 2020 Goal:** MC: HbA1c Control (<8.0%): 60.77% OC: HbA1c Control (<8.0%): 71.97% OCC: HbA1c Control (<8.0%): 71.97%	1) Targeted outreach to members in "emerging risk" category (8.0-9.0) 2) Track the number of completed calls to emerging risk members identified	Pshyra Jones/ Helen Syn/ Mimi Cheung	Helen reported to QIC 2/11: Health coaches are outreaching to members who recently were above A1C >8% to identify the cause for the increase and support efforts to reduce it with behavior modification and/or better medication adherence. **2020 March Prospective Rate (A1c >8; Adequate Care - (PR):** MC: 11.48% OC: 11.03% OCC: 16.22% Measure is performing better than same time last year for MC and OCC and lower for OC	Continue to ongoing call outreach to members identified >8% for timely addressing of modifiable behavior related to better medication management, exercise or nutrition management.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS 2020 Goal:** MC: Eye Exam: 64.72% OC: Eye Exam: 78% OCC: Eye Exam: 78%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization	Pshyra Jones/ Helen Syn/ Mimi Cheung	**CDC A1c:** **1) # of Eye Exam - 2020 member incentives processed by 3/31/20: 1; To be processed: 2** Direct mailing to member scheduled for June 2020. **2020 March Prospective Rate (PR):** MC: 32.57% OC: 45.96% OCC: 41.29% Measure is performing better than same time last year for MC and OC and lower for OCC.	Incentive for all LOBs has been promoted to Health Networks, but direct to member incentive mailing is scheduled in June/July 2020. Due to the COVID19 situation, we assume a decline in appointments being scheduled for non-urgent vision care.	
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	**HEDIS 2020 Goal:** Prenatal MC 86.37% Postpartum MC 68.36%	1) Implement $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments	Ann Mino	**1) # of PPC 2020 member incentives processed by 3/31/20: 85; To be processed 10** **2) 2020 March Prospective Rate (PR):** Medi-Cal only: Prenatal: 87.27% Postpartum: 54.66% Measure is performing better than same time last year.	Incentive has been promoted to Health Networks, but direct to member incentive mailing is scheduled in June/July 2020. Due to the COVID19 situation, we assume a decline in what members may perceive as non-urgent appointments. Telehealth visits being promoted for postpartum visits.	

2020 QI Work Plan 1Q

2020 QI Work Plan Element Description	Goals	Planned Activities	**Staff Responsible**	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.*)	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF SERVICE						
Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	Improve Member Experience for **Getting Needed Care** from 25th to 50th percentile AND Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	1) Continue Provider Data Initiative 2) Update the CalOptima Website (Provider Directory) so that providers and services are easily accessible to members 3) To have HN meet Time and Distance Standards 4) To have HN have at least 1 urgent care enter int he provider directory. 5)Provider Coaching and Workshops, report on # of Physician Shadow Coaching and Customer Service Improvement Workshops	Marsha Choo	All of the project listed are being monitored and reviewed by the Member Experience Sub-Commmitee. 1) As DHCS reviews CalOptima's 274 file and provides quarterly feedback, CalOptima works to clean and update FACETs and the 274 file. In this quarter, CalOptima re-configured the 274 file to accurately reflect all provider addresses, so that network adequacy reports and analysis accurately reflect our provider network. 2) CalOptima's Website was updated to create a search function specificially for urgent care centers at the provider directory home page rather than to have member search for urgent care centers in the list of specialists. 3) CalOptima submitted the Annual Network Certification (ANC)to DHCS on time. DHCS rejected the submission stating that CalOptima's analyses did not monitor for 'anticipated membership'. CalOptima resubmitted the ANC using the "Percent of Census" methdology, which was accepted by DHCS and CalOptima met all time and distance standards at the plan level. CalOptima also submitted the Plan of Action for the Subcontracted Network Certification and the plan was approved by DHCS. 4) CalOptima reached out to the HNs to confirm their contracted urgent care centers and the provider directory was updated to accurately reflect their network of urgent care centers. 26 MC, 33 OC and 44 OCC urgent care centers was added to the directory. 5) No provider coaching nor workshops were conducted in this quarter. A couple of provider offices were committed to conduct a workgroups. However, due to COVID-19, the workshops were placed on hold until further notice.	1) Provider relations and IS are working together to clean up with provider taxonomy in FACETs and the 274 file. 2) Urgent care center search function is 5th on the Provider Directory home page and CalOptima would like to move that up to first after the emergency message. 3) CalOptima will use the newly approved methodology to run the time and distance analyses at the plan level and share the results with the executive team and the HNs, as part of the Plan of Action. 4) Continue to review and monitor data 5) On hold until further notice.	
Review of Timely Access - Increase appointment availability	Improve Timely Access for **Compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists** from current rate to 80%	1) Increase payment rates for hard to access specialists 2) Contract with Telehealth vendor and initiate telehealth services for identified specialties. 3) Incentive for hard to access PCPs/Specialists to open their panels 4) PCP Overcapacity Monitoring and closing of panels 5) Offer After Hours Incentive	Marsha Choo	CalOptima fielded the Timely Access Survey in 2019 and did not meet the internal standard of 80% for primary care nor specialty providers. For primary care, the compliance rate was 67% for non-urgent appointments and 21% for urgent appointments. For specialty care, the compliance rate was even lower with a compliance rate of 58% for non-urgent appointments and 16% for urgent appointments. All of the project listed are being monitored and reviewed by the Member Experience Sub-Commmitee. 1) On hold 2) CalOptima is preparing an RFP for an afterhours physician service that includes e-consult. 3) On hold 4) While CalOptima continues to monitor PCP capacity, CalOptima has placed a hold on closing provider panels if the are overcapacity due to COVID-19. CalOptima will continue to open PCP panels if they meet capacity for 3 consecutive months. 5) $2 million was approved by the Board of Directors in April to initiate the Extended Office Hours Pilot Program.	Data from the Timely Access Data will be reviewed and analyze by the Timely Access workgroup to develop initiatives to improve access. Data will be shared with the HN. 1) On hold 2) Issue the RFP Process to select a vendor. 3) On hold 4) Continue to monitor and open panels. Closed panels on hold until further notice. 5) CalOptima staff to present this program to the HNs at the HN Forum and move toward inplementation.	

2020 QI Work Plan 1Q

2020 QI Work Plan Element Description	Goals	Planned Activities	**Staff Responsible**	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.*)	Red - At Risk Yellow - Concern Green - On Target
IV. SAFETY OF CLINICAL CARE						
Plan All-Cause Readmissions (PCR)	**HEDIS 2020 Goal:** OC 8%; OCC 8%	1) Complete RFP and select vendor to collect ER data, and reinstate ER discharge program 2) Track # of Members receiving health coaching 3) Track # of member with a hospital admission versus unplanned readmission	Sloane Petrillo Helen Syn/ Jocelyn Johnson	**2020 March Prospective Rate (PR):** MC: 10.31%; lower OC: 13.33% OCC: 9.60%% Measure is performing better than same time last year for all LOBs **OCC CHF Transition of Care Q1 2020:** Of the 7 identified CHF related admissions: 2 Members went to SNF 1 Member was coached but ended up in the hospital within 30 days from discharge 1 Member was UTC 1 Member expired 1 member refused health coaching but was not re-admitted to the hospital. 1 Member received health coaching and was not re-admitted.	RFP is in review with executive leadership. Health Coaches will continue to outreach members with readmits as they are identified.	
Opioids Utilization	Optimal utilization of opioid analgesics.	Interventions: a. Quantity limits b. Duration limits c. Prior Authorization criteria d. Prescriber Report Cards e. Pharmacy Home f. Prescriber Restriction	Kris Gericke/N. Ghazanfarpour	Goal: Average Morphine Milligram Equivalent (MME)/Member <15.5 1Q19: 13.9 1Q20: 12.0	Goal met. Continue interventions and monitoring.	
Post-Acute Infection Prevention Quality Incentive (PIPQI), aka as SHIELD OC	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	Cathy Osborn	QIC Update on 3/10/2020 (PIPQI) Goals Met: 1. Twenty-Four nursing facilities participating; 2. Two CalOptima nurses assigned to the project; 3. Each facility visited at lest one time per month. QIC Update on 5/12/2020 1. On April 2, 2020 - CalOptima BOD approved a $3.4 millian dollar expansion - including an additional $7,500 quarterly incentive. 2. On April 27, 2020 - Q1 and Q2 incentives distributed to facilities ($15,000) to help with the cost of PPEs	Continue to monitor; establish baseline; submit project proposal to DHCS for PDSA.	

Board of Directors' Quality Assurance Committee Meeting
September 16, 2020

Program of All-Inclusive Care for the Elderly
Quality Improvement Committee
Second Quarter 2020 Meeting Summaries

May 12, 2020: Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Committee (QIC), (PQIC)Meeting and PACE Infection Control Subcommittee Summary

- All PQIC members present.
- Infection Control Subcommittee
    - Dr. Miles Masatsugu provided an Orange County COVID-19 update.
    - Nursing home COVID-19 outbreaks continue to be an issue that we will monitor closely.
    - As of May 11, 2020, the cumulative number of PACE participants who have tested positive for COVID-19 is two.
    - PACE response to COVID-19:
        - Daily wellness calls to all participants
        - Significant increase in home-based services
        - Significant increase in home delivered meals
        - Care kits (i.e. masks, activities) provided to all participants.
        - Finalized a contract with a mobile phlebotomy vendor
        - Developed and implemented new electronic medical record (EMR) telehealth workflows.
        - Telehealth workgroup formed and obtained data ascertaining the capability of participants to engaging in telehealth visits.
            - 58% of participants have been trained in utilizing either FaceTime or Google Duo.
            - 29% of participants required either a device or bandwidth to engage.
            - 13% of participants required follow-up evaluations. This will be a part of phase two.
        - The telehealth workgroup is exploring permanent telehealth platforms.

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- Membership: Membership continues to be at projected goals. Discussions centered around adequately providing continued specialty care for new enrollees considering the COVID-19 pandemic.
- Immunizations: Participants received 191 vaccines via a drive-through immunization campaign. Medical providers will schedule a follow-up conference call with participants who refuse vaccinations.
- Falls without Injury: The number of falls without injury dropped slightly from previous quarter. The falls occurring were due to some participants are not using durable medical equipment (DME) as recommended at home. The interdisciplinary teams will address this.
- Appeals and Grievances: Overall, we had a very low number of appeals and grievances filed. Only one appeal and four grievances were filed in this quarter. Three of the four grievances centered around transportation-related issues.
- Medication Errors: Three errors reported during the quarter. No adverse events were recorded. Staff was counseled.
- Unusual Incidents: There were eight falls with injury reported for the quarter. It was noted that several falls occurred while participants resided in a skilled nursing facility. The PACE QI manager followed up with the director of nursing of the facilities regarding the incidents. Root Cause Analyses are conducted for each unusual incident.
- Quality Initiatives: 2020 Quality Initiatives were introduced:
    - Advance Health Care Directive: The goal is to provide participants with the opportunity to complete a directive that designates an agent to make health care decisions in the event that the participant becomes incapable of doing so.
    - Immunizations: The goal is to develop an immunization dashboard profiling immunization status of participants. Initially, the focus is on the administration of both Prevenar 13 and Pneumovax 23.

June 9, 2020: PQIC Meeting and PACE Infection Control Subcommittee Summary

- All PQIC members present.
- Infection Control Subcommittee
    - 11,000 Wellness Calls placed to participants since mid-March 2020.
    - Drive-thru clinic visits initiated for COVID-19 testing and to provide immunizations.
    - Telehealth workgroup has been researching short-term and long-term solutions for continued participant care. This includes assessing participant's comfort level in utilizing technology, reviewing demonstrations of various telehealth platform vendors, reviewing options for providing participants with devices.

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        - 67% of our participants are now set up to engage in telehealth encounters through either FaceTime or Google Duo.
    - Implementation of "PACE without Walls." This is a home-based care model providing in-home skilled and non-skilled services in addition to contracted vendors.
- Improve the Quality of Care for Participants: Q1, 2020:
    - Membership: PACE is at goal.
    - Immunizations: The pneumococcal and influenza vaccination rates were both at 90%. Of those who did get immunizations, 7% of participants refused the influenza vaccination, and 4% refused the pneumococcal immunization. The COVID-19 outbreak has affected the opportunity to vaccinate new enrollees. We have already started planning for the 2020 influenza season and anticipate the delivery of the influenza vaccine in August 2020. We will administer the flu and pneumococcal vaccine concurrently, as appropriate, and will restart the drive-thru immunization clinics once we received our first shipment of the vaccines.
    - Infection Control: We remain below the National Benchmark (lower is better), although the rate of respiratory infections increased slightly year over year. We expect these rates to increase this year due to COVID-19 and will continue to monitor closely.
    - Physician Orders for Life-Sustaining Treatment (POLST): We were above our goal with 97% of the participants having completed a POLST. Our goal was 95%.
    - Functional Assessments: 99.2% have been completed. Three were missed due to the participant's vacation status.
    - Comprehensive Diabetes Care:
        - Blood Pressure Control: We fell below our goal for this indicator with a rate of 72% versus a goal of 81.5%. The medical team felt this was due to the transition to our new providers. Moving forward, providers will be given lists of participants who do not meet the benchmarks with whom they will follow up.
        - Eye Exams: We are above goal with a rate of 97% versus the goal of 85.33%.
        - Nephropathy Monitoring: We continue to be above goal with 99% being monitored versus a goal of 98.3%.
    - Drug/Disease Interactions in the Elderly: We are slightly below goal with a rate of 37% versus a goal of 35.73% (lower is better). The pharmacist has been assisting in alternative medication recommendations.
    - Medication Reconciliation Post-Discharge: We are above goal in this indicator with a rate of 98% versus a goal of 90%.
- Ensure Safety of Clinical Care:

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  - Use of Opioids at High Dosages: Two participants are included in this group and are actively managed by their primary care physician (PCP).
  - Day Center Falls: A team (medical provider, nursing supervisor, clinical medical director, physical therapist, therapy aid and pharmacist) are dedicated to tracking the falls. We have seen an increase in the falls at home. It was found that most of these falls occurred due to participants not using their DME as instructed. Inter Disciplinary Team (IDT) will follow up with these participants.
- Ensure Appropriate Use of Resources:
  - Access to Specialty Care: There has been decreased access to specialty care during the COVID-19 shutdown. One of our major specialty care providers, UCI Health, began to utilize telehealth for our participants. Even with these issues, we met our goal of 80%, however, we will continue to monitor closely.
  - Hospital/ER/Readmissions Utilization.
    - 30-day Readmission: The rate is below our goal at 12% and lower than our Q1, 2019 rate of 16%.
    - Acute Hospital Stays: We did see a fall in our inpatient bed days in Q1, 2020 compared to Q1, 2019. We anticipate that we will see a drop in Q2 due to the health emergency as fewer participants are going to the hospital. PACE continues to make daily wellness calls to all our participants to ensure that they are not delaying care due to the COVID-19 pandemic.
    - Emergency Room Utilization: Our quarterly numbers have decreased. More participants are calling the after-hours service since they are resistant to going to the ER. We also expect these rates to drop in Q2, 2020.
  - Long-Term Care: 2% of the participants are in long-term care, which continues to be significantly lower than the state average. We are attempting to relocate participants who are in custodial care to home in view of the health emergency.
- Improve Participant Experience:
  - Disenrollments: We had 28 disenrollments in Q1. The most common reasons for disenrollments are language and hospice.
  - Transportation: On-time performance is over 95%. We expect our volume to increase due to more clinic, physical therapy (PT) and occupational therapy (OT) visits. Due to the health emergency, we are only transporting one participant per vehicle.
- PACE Desk References: Two new desk references were presented and approved by the committee.

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Member Trend Report: 1st Quarter 2020

Quality Assurance Committee

September 16, 2020

Ana Aranda, Director, Grievance and Appeals Resolution Services

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Overview

- Breakdown of complaints by category
- First quarter trends in rate of complaints (appeals/grievances)
  - Per 1,000 member months for Medi-Cal program
  - Per 1,000 members for OneCare and OneCare Connect programs
- 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 a CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction
- Quality of Care (QOC): Concerns regarding care the member received or feels should have been received

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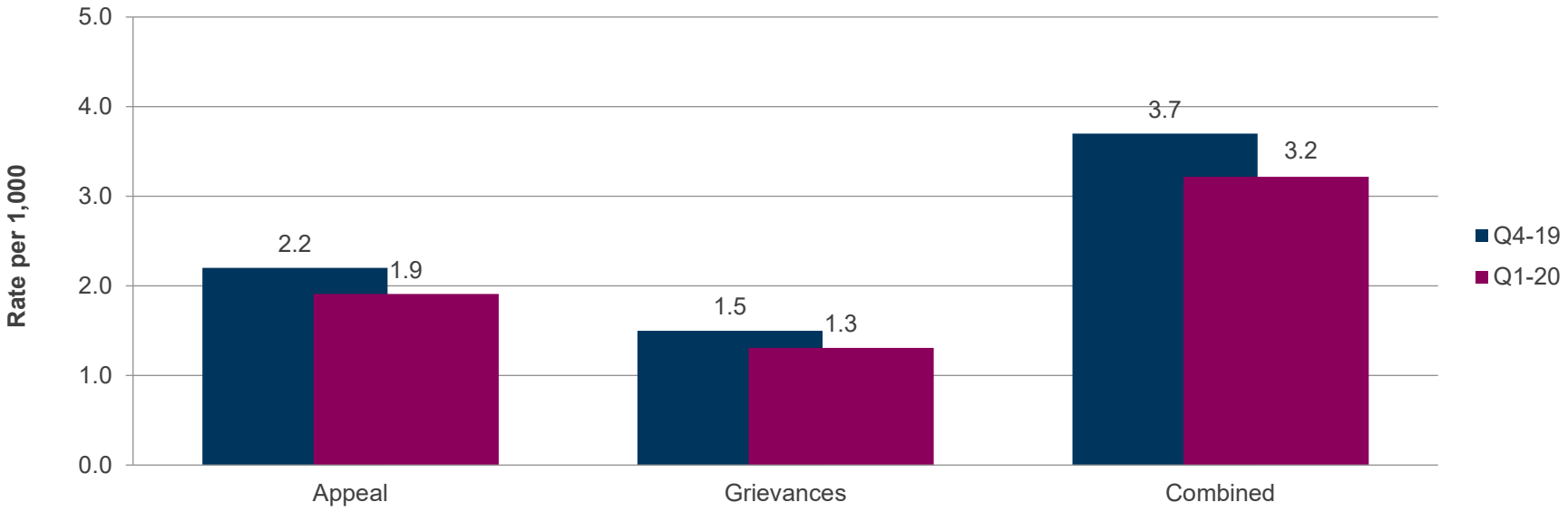
Medi-Cal Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q4-2019	3,766	402	3,364	732,116
Q1-2020	3,090	334	2,756	701,662

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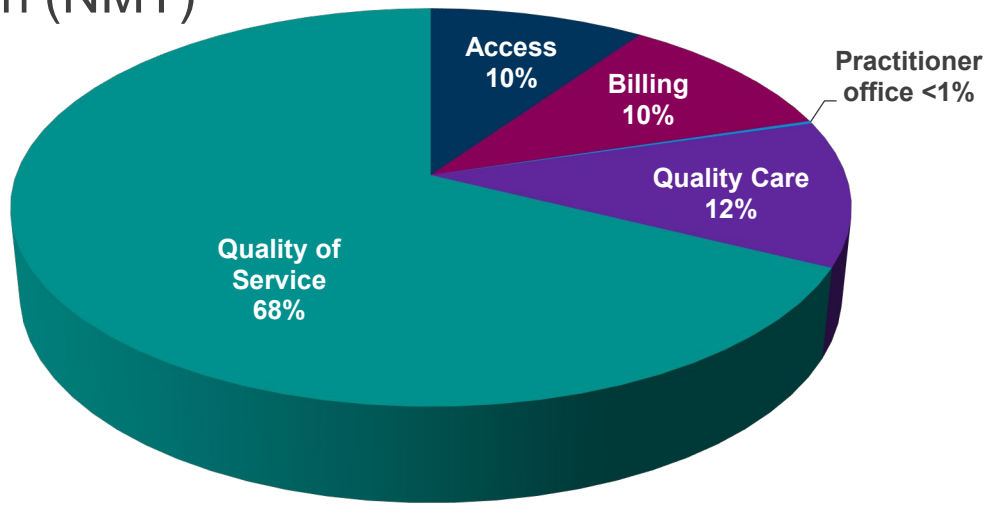
Medi-Cal Grievances by Category

- Top grievance types
  - Delays in service
  - Question treatment
  - Non-medical transportation (NMT)
  - Provider/staff services
  - Member billing



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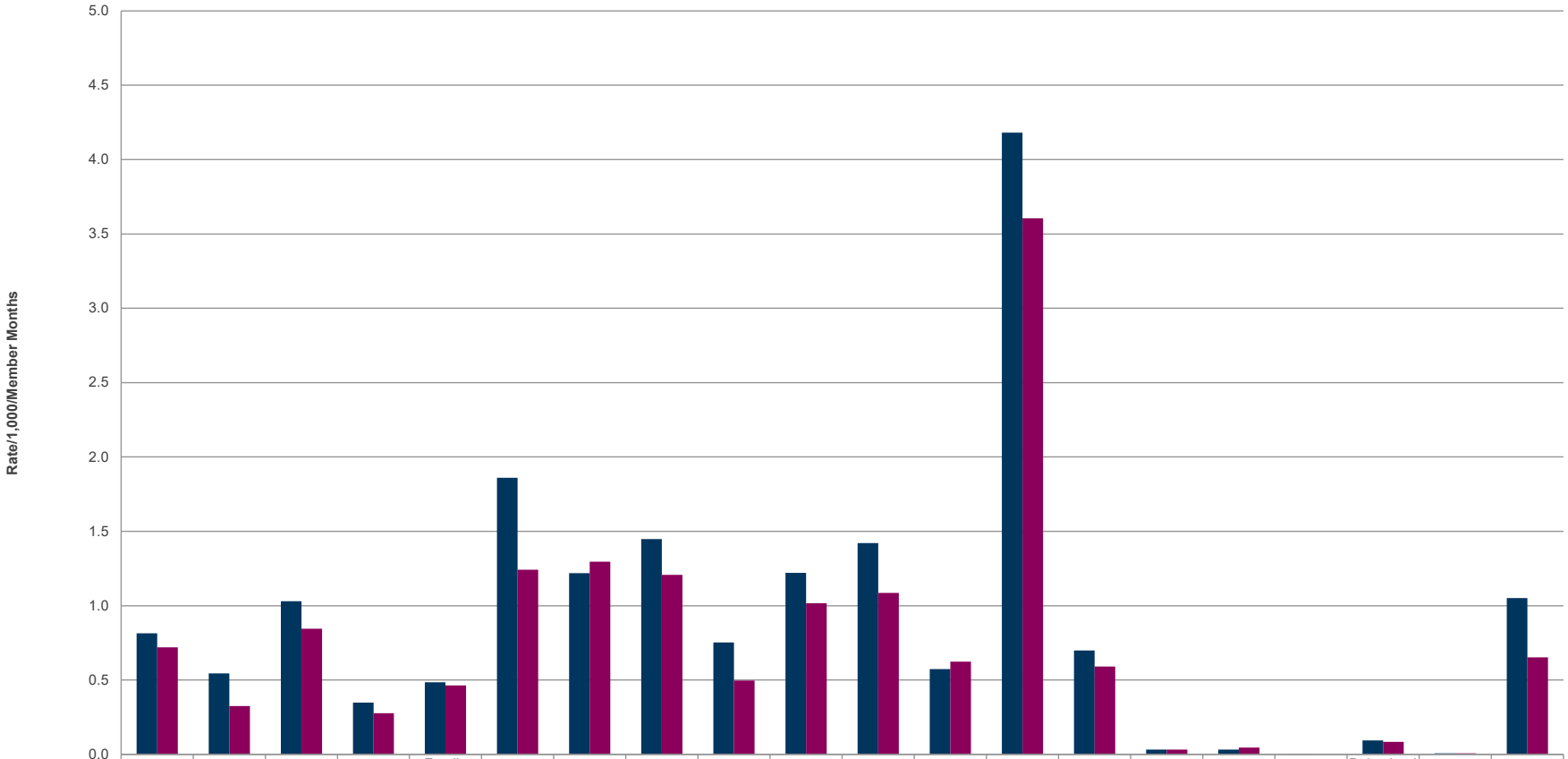
Medi-Cal Member Grievances Quarterly Rate/1,000



	AltaMed (37,510)	AMVI (20,498)	Arta (57,135)	CHA (139,186)	Family Choice (42,299)	Heritage (6,442)	Kaiser (42,450)	Monarch (74,800)	Noble (18,768)	Prospect (32,448)	Talbert (22,386)	UCMG (32,016)	CCN (78,767)	COD (96,959)	CO Prog (701,662)	CO Pharm (659,212)	MLTSS (659,212)	Behavioral Health (701,662)	VSP (659,212)	Veyo, LLC (121,872)
Q4-19 (3364)	0.8	0.5	1.0	0.3	0.5	1.9	1.2	1.4	0.8	1.2	1.4	0.6	4.2	0.7	0.03	0.03	0.00	0.1	0.01	1.1
Q1-20 (2756)	0.7	0.3	0.8	0.3	0.5	1.2	1.3	1.2	0.5	1.0	1.1	0.6	3.6	0.6	0.03	0.05	0.00	0.1	0.01	0.7

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Medi-Cal Summary

- Grievances decreased by 18% from Q4 2019 to Q1 2020
  - Quality of service grievances decreased by 23%
  - Access grievances decreased by 13%
  - Billing grievances decreased by 3%
- Non-medical transportation grievances decreased by 35%
  - 5% increased utilization of non-medical transportation benefit from Q4

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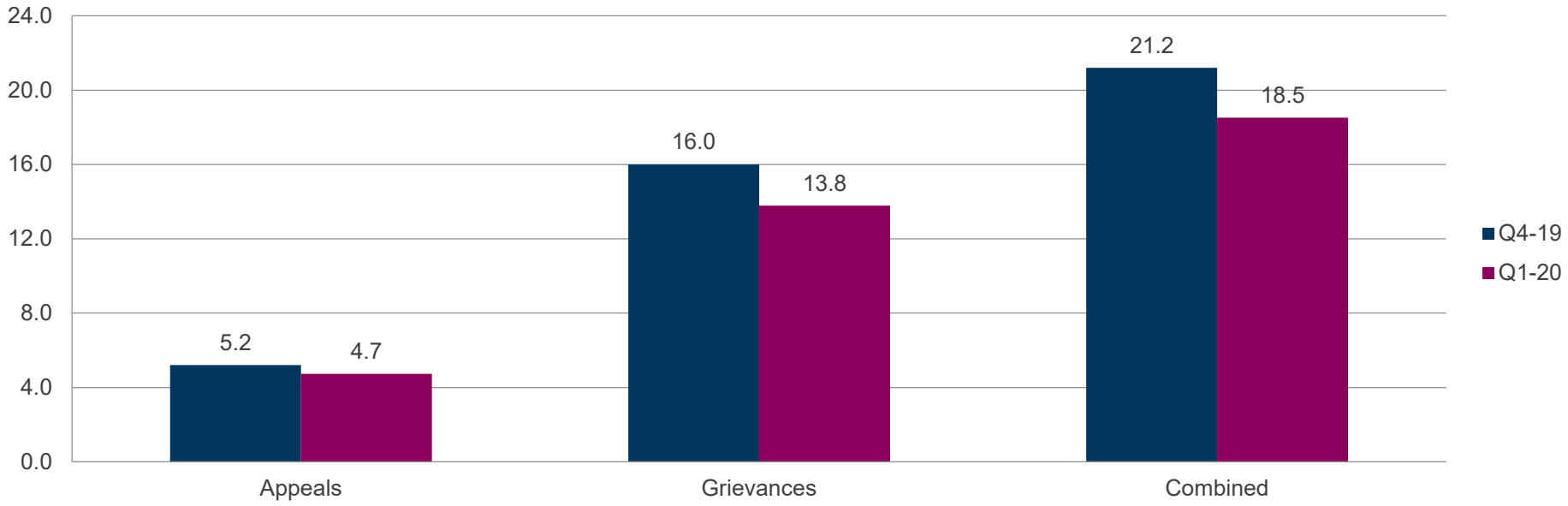
OneCare Connect (OCC) Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q4-2019	302	74	228	14,252
Q1-2020	262	67	195	14,148

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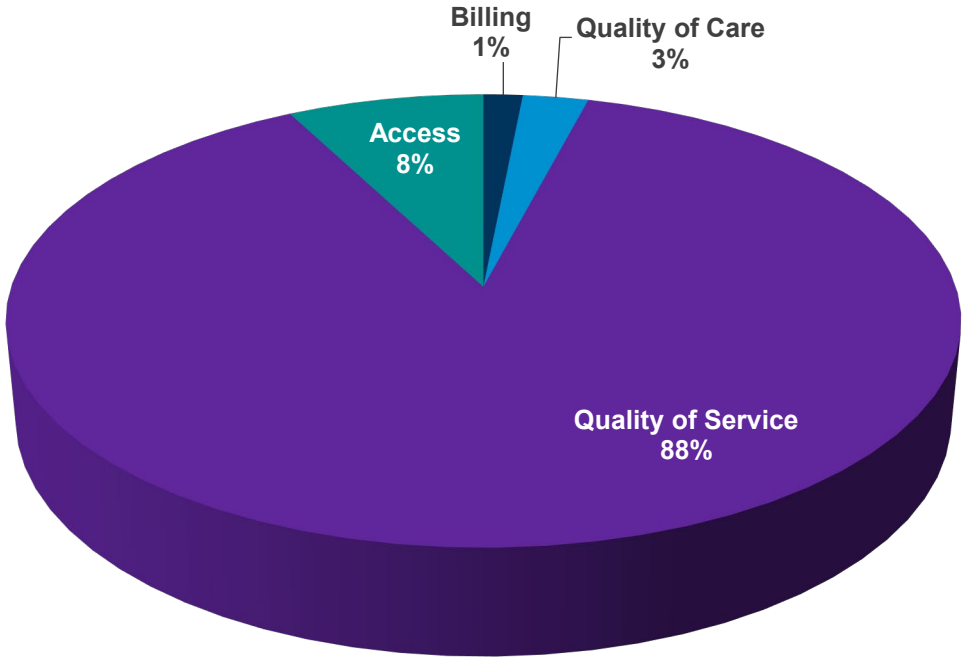
OCC Grievances by Category

- Top grievance types
  - Non-medical transportation (NMT) services
  - Provider services
  - Primary care provider



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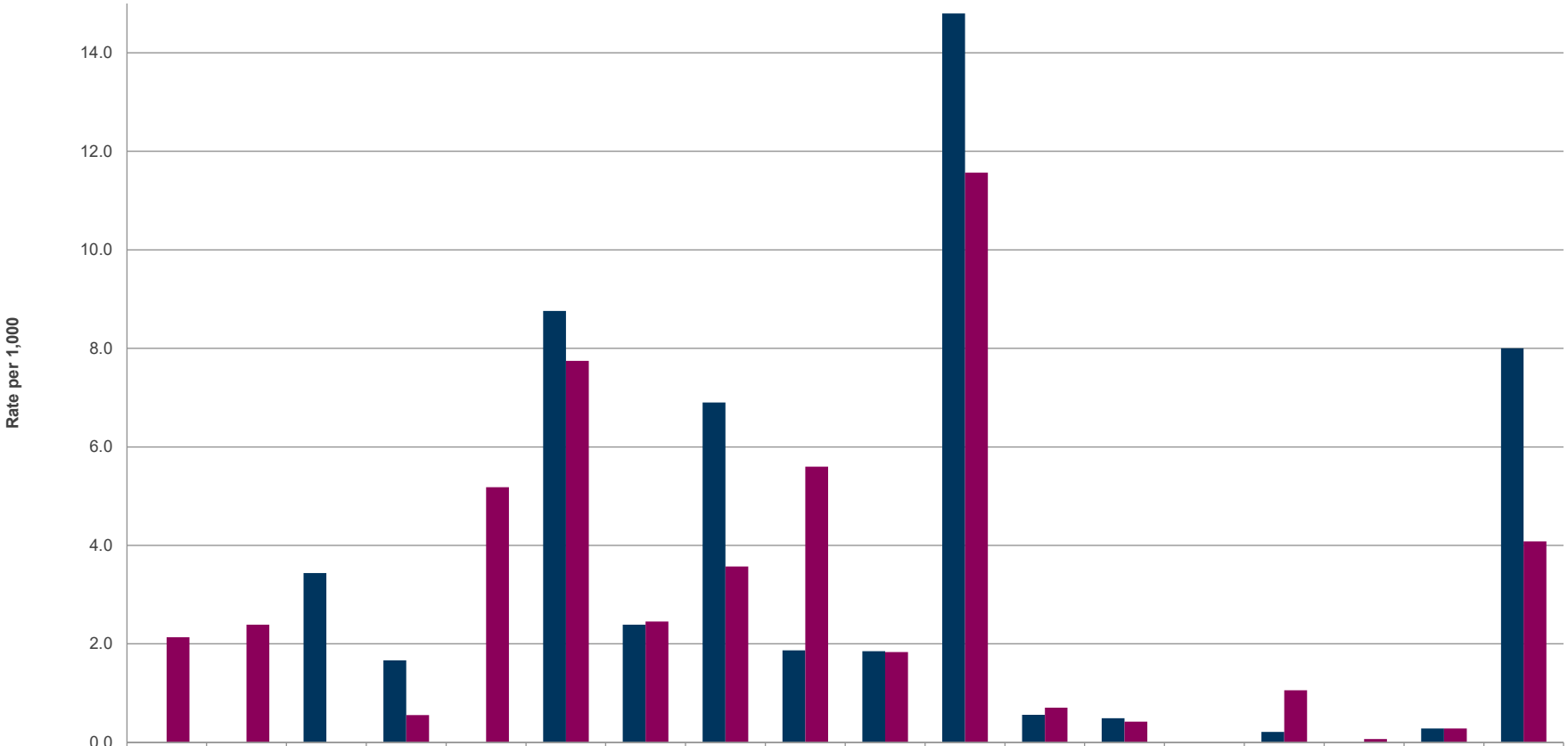
OCC Member Grievances Quarterly Rate/1,000



	Alta Med Health (469)	AMVI Care (418)	Arta (582)	Family Choice (1,800)	Heritage (193)	Monarch (4,519)	Noble (408)	Prospect (2,240)	Talbert (1,072)	UCMG (545)	CCN (1,902)	OCC Ops (14,148)	OCC Pharm (14,148)	MLTSS (14,148)	Behavioral Health (14,148)	Silver and Fit (14,148)	VSP (14,148)	Veyo (20,106)
Q4-19 (228)	0.0	0.0	3.4	1.7	0.0	8.8	2.4	6.9	1.9	1.8	14.8	0.6	0.5	0.0	0.2	0.0	0.3	8.0
Q1-20 (195)	2.1	2.4	0.0	0.6	5.2	7.7	2.5	3.6	5.6	1.8	11.6	0.7	0.4	0.0	1.1	0.1	0.3	4.1

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OCC Summary

- Grievances decreased by 13% from Q4 2019 to Q1 2020
  - Quality of service grievances decreased by 16%
  - Quality of care decreased by 58%
- NMT grievances decreased by 28%
  - 4% decreased utilization of NMT benefit from Q4

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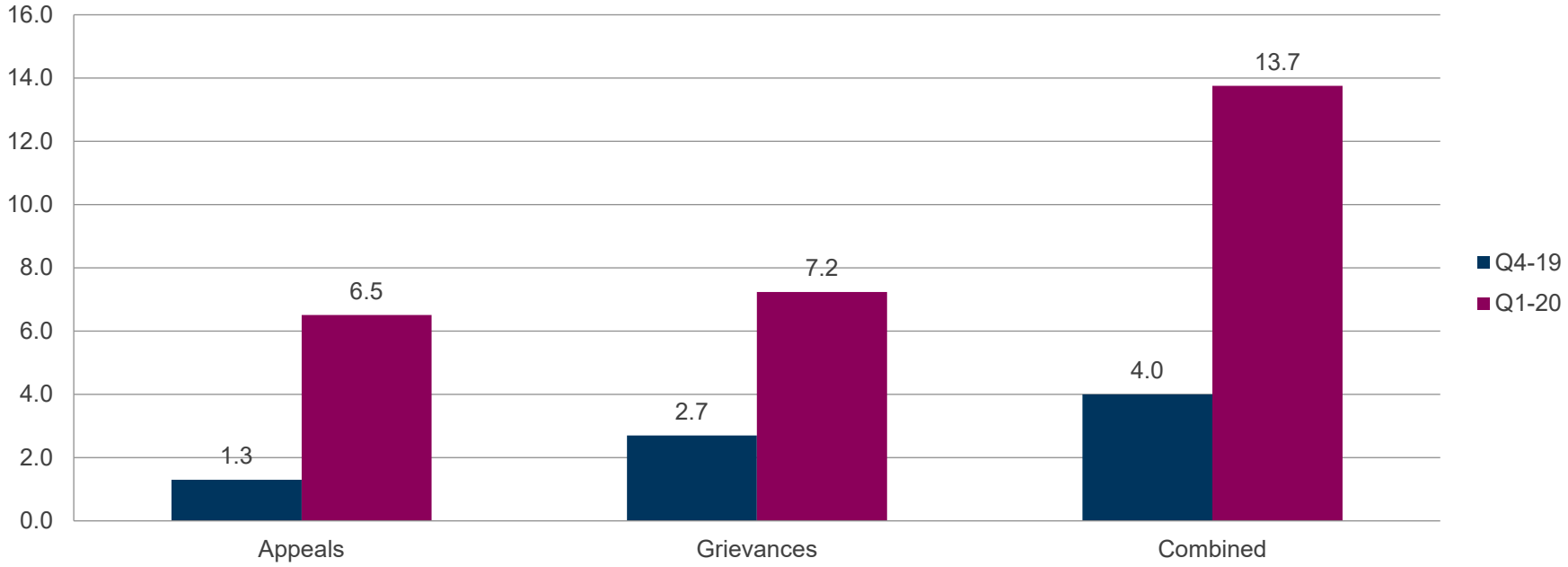
OneCare Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q4-2019	6	2	4	1,509
Q1-2020	19	9	10	1,382

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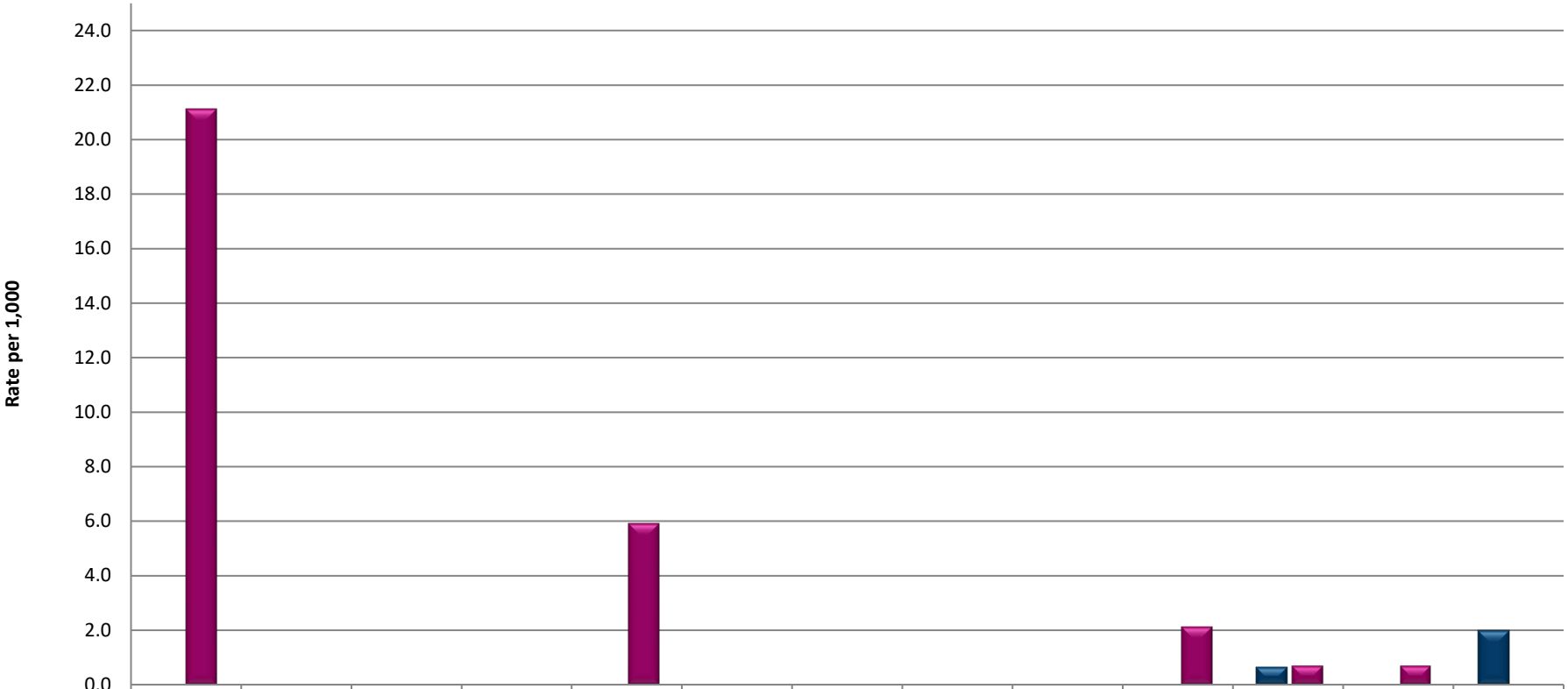
OneCare Member Grievances Quarterly Rate/1,000



	Alta Med Health (47)	AMVI/ Prospect (258)	Arta Western (104)	Family Choice (85)	Monarch (670)	Noble (27)	Talbert (138)	UCMG (54)	OC Operations (1,382)	OC Pharm (1,382)	Behavioral Health (1,382)	VSP (1,382)	Veyo (197)
Q4-19 (4)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.0	2.0
Q1-20 (10)	21.1	0.0	0.0	0.0	6.0	0.0	0.0	0.0	0.0	2.2	0.7	0.7	0.0

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OneCare Summary

- Grievances remain relatively low
  - 150% increase (4 to 10) from Q4 2019 to Q1 2020
- Grievances were due to the following:
  - Pharmacy services
  - HN/PMG staff
  - Appointment availability/cancellations
  - Provider demeanor
  - Billing

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Overall Interventions

- Grievance trends continue to be reviewed with the Quality Improvement department and shared with Provider Relations leadership for further action.
- Provider Relations staff continue outreach to providers with high grievance counts to provide awareness and education.

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Our Mission

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

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