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

WEDNESDAY, SEPTEMBER 14, 2022
3:00 P.M.

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

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

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL KENNADAY LEAVITT	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo	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 materials are available for review at CalOptima Health, 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:
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_oLJrIEzvR7SP2OmjjFxcZQ and Join the Meeting.
Webinar ID: **837 5098 5389**
Passcode: **277479** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

MANAGEMENT REPORTS
1. Chief Medical Officer Report

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

CONSENT CALENDAR
2. Approve Minutes of the June 8, 2022 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORT ITEMS

3. Approve Modifications to CalOptima Health Policies AA.1207a and AA.1207b

INFORMATION ITEMS
4. Department of Health Care Services Comprehensive Quality Strategy

5. HEDIS Measurement Year 2021 Results

6. Quality Initiatives Update

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

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee on September 14, 2022 at 3:00 p.m. (PST)

Join from a PC, Mac, iPad, iPhone or Android device:

Please click this URL to join:
https://us06web.zoom.us/webinar/register/WN_oLJrIEzvR7SP2OmjjFxcZQ

Or One tap mobile:
+16694449171,,83750985389#,,,,*277479# US
+17207072699,,83750985389#,,,,*277479# US (Denver)

Or join by phone:
Dial (for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 720 707 2699 or +1 253 215 8782 or +1 346 248 7799 or +1 719 359 4580 or +1 646 931 3860 or +1 301 715 8592 or +1 309 205 3325 or +1 312 626 6799 or +1 386 347 5053 or +1 564 217 2000 or +1 646 558 8656

Webinar ID: **837 5098 5389**
Passcode: **277479**

International numbers available: https://us06web.zoom.us/u/kZAR12O1k

Health Network Quality Dashboard

(Calendar Year 2020)

CalOptima Health

Line(s) of Business: Medi-Cal
Health Network(s): All

Health Network (Medi-Cal Risk Type)	Average Members	HEDIS Medi-Cal Quality Score	CAHP Medi-Cal Survey Quality Score	Total Medi-Cal Quality Score	Acute IP Bed Days Per 1,000 Mbrs*
AltaMed (SRG)	40,199	4.0	2.0	3.5	350.6
AMVI (PHC)	22,635	4.0	1.0	3.0	173.1
CHOC (PHC)	145,082	4.0	3.0	4.0	113.5
Family Choice (PHC)	44,408	3.0	1.0	2.5	231.8
HPN Regal (HMO)	7,162	3.0	2.0	2.5	257.3
Kaiser (HMO)	45,655	4.5	4.5	4.5	177.1
Noble (SRG)	19,625	3.0	1.5	2.5	404.2
Optum - Arta (SRG)	61,081	3.0	3.0	3.0	295.9
Optum - Monarch (HMO)	80,104	3.0	2.0	2.5	294.4
Optum - Talbert (SRG)	24,253	3.0	2.0	2.5	299.6
Prospect (HMO)	35,299	3.0	1.5	2.5	300.3
United (SRG)	34,455	3.0	2.0	2.5	211.3
CCN (FFS)	102,538	3.0	2.5	3.0	688.1
Total	**662,495**	**3.3**	**2.2**	**3.0**	**301.9**

*Bed Days do NOT include Crossover Claims (claims where CalOptima is the secondary payer).

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CalOptima Health Hospital Quality Dashboard
CY2021 CMS Star Ratings

Group	Hospitals	Hosp Quality Star Rating (CY2021)*
CHOC	Children's Hospital of Orange County	-
	CHOC Children's at Mission Hospital	-
UC SYSTEM	UCI Medical Center	★★★
TENET	Fountain Valley Regional Hospital & Medical Center	★★
	LOS ALAMITOS MEDICAL CENTER	★
	Placentia Linda Hospital	★★
PROVIDENCE	Providence Mission Hospital	★★★★
	Providence St Joseph Hospital	★★★★
	Providence St Jude Medical Center	★★★★
KPC	Anaheim Global Medical Center	★
	Chapman Global Medical Center	★★
	Orange County Global Medical Center	★★
	South Coast Global Medical Center	-
PRIME	Garden Grove Hospital Medical Center	★★★★
	West Anaheim Medical Center	★★★
	Huntington Beach Hospital	★
	La Palma Intercommunity Hospital	★★★★
Other Major Hospitals	College Hospital Costa Mesa*	-
	Anaheim Regional Medical Center	★★★
	Foothill Regional Medical Center*	-

Hospital Quality Rating: https://data.cms.gov/provider-data/dataset/xubh-q36u

*CMS star ratings are not available for pediatric or specialty hospitals

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

June 8, 2022

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on June 8, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings.

Acting Chair José Mayorga, called the meeting to order at 3:00 p.m. and Director Shivers led the Pledge of Allegiance.

CALL TO ORDER

Members Present: José Mayorga, M.D. Acting Chair; Nancy Shivers, R.N. (all members participated via teleconference)

Members Absent: Trieu Tran, M.D., Chair

Others Present: Richard Pitts, D.O., Ph.D., Chief Medical Officer; Monica Macias, Director PACE, Katie Balderas, Director Population Health Management; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the March 9, 2022 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

2. Approve Modifications to CalOptima Policy GG: 1611: Potential Quality Issue Review Process

3. Approve New CalOptima Policy GG. 1666p: Mobile Texting Program

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

INFORMATION ITEMS

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

Ms. Macias provided an update on the recent activities of the PACE Member Advisory Committee. Ms. Macias also mentioned that the PACE Center member vaccination rate is at 96% and participant satisfaction results scored a 91% with CalOptima's PACE services.

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Dr. Pitts commended the work of Ms. Macias and her team with the vaccination rate and attributed the high rate of vaccinations to PACE members trusting the staff at the PACE center.

Agenda Items 6.a. through 6.c. were accepted as presented.

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

6.d. Health Equity Update

Katie Balderas, Director Population Health Management, provided an update on the health equity framework. Ms. Balderas discussed the on-going work of the interdepartmental workgroup and the build-out of the health equity roadmap.

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

ADJOURNMENT
Hearing no further business, Acting Chair Mayorga adjourned the meeting at 3:27 p.m. The next Quality Assurance Committee meeting is scheduled for September 14, 2022.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 14, 2022

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Take September 14, 2022
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item
3. Approve Modifications to CalOptima Health Policies AA.1207a and AA.1207b

Contacts
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591
Kelly Rex-Kimmet, Director, Quality Analytics, (714) 235-6937

Recommended Actions
Approve recommended modifications to the following existing policies and procedures, in accordance with CalOptima Health's regular review process and regulatory requirements:

1. Policy AA.1207a: CalOptima Auto-Assignment.
2. Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology.

Background/Discussion
CalOptima Health staff regularly review agency policies and procedures to ensure that they are up-to-date and aligned with federal and state health care program requirements, contractual obligations, and laws, as well as CalOptima operations.

1. **Policy AA.1207a: CalOptima Auto-Assignment** establishes a process by which CalOptima shall assign a Member who has not voluntarily selected a Health Network, or CalOptima Community Network (CCN), to a Health Network, or CCN. Policy AA.1207a was updated to clarify that CCN is included in the auto-assignment process and add guidance for allocation of auto-assignment for Whole Child Model (WCM) members.

2. **Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology** establishes CalOptima's methodology for determining a Health Network and CCN's assignment allocations according to performance-based indicators. Policy AA.1207b was modified to update the quality metrics and scoring methodology used in auto-assignment allocation.

   The updated quality metrics and scoring methodology have been shared and discussed with the Health Networks at Health Network forums, quality forums, and the Quality Improvement Committee.

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

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Additionally, glossaries for both policies have been updated to add definitions for California Children Services (CCS) Program, Member, Primary Care Provider, Shared Risk Group, and WCM, as applicable.

1. **Policy AA.1207a: CalOptima Auto-Assignment**

Policy Section	**Changes**
Page 1. Section: II. C. b.	Added "Member Experience" as a second category of quality metrics for auto assignment.
Page 1 Section: II. D.	Added language to preserve existing member to provider relationship within the Auto Assignment process.
Page 3. Section III. C. 1.	Added language to clarify assignment of family linked members, eligible with WCM to Health Networks participating in WCM.
Page 4. Section III. E-H	Added process to ensure CCS-eligible members are not assigned to a Health Network excluded from the WCM program.

2. **Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology**

Policy Section	**Changes**
Page 1. Section: II. C. b.	Added "Member Experience" as a second category of quality metrics for auto assignment.
Page 2. Section II. C. a-c.	Added language that describes the new quality ratings and scoring methodology. Quality metrics scoring were changed to align with industry standards to establish minimum performance levels and to drive higher health plan quality performance scores.
Page 3. Section II. G.	Added language defining requirements for auto-assignment for new Health Networks.

Fiscal Impact

The recommended action to approve changes to AA.1207a and AA.1207b is operational in nature and has no additional fiscal impact beyond what was included in the CalOptima Fiscal Year 2022-23 Operating Budget.

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Rationale for Recommendation

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

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Policy AA.1207a CalOptima Auto-Assignment
2. Policy AA,1207b Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology
3. Presentation: Changes to Auto-Assignment Quality Metrics and Scoring

/s/ Michael Hunn *09/08/2022*
Authorized Signature **Date**

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Policy:	AA.1207a
Title:	**CalOptima Auto-Assignment**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy ~~outlines the~~establishes a process by which CalOptima ~~assigns~~shall assign a Member who has not voluntarily selected a Health Network, or CalOptima Community Network (CCN), to a Health Network, or CCN.

II. POLICY

A. A Health Network ~~Eligible~~ eligible Member shall select a Health Network~~,~~ or CCN~~,~~ in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If a Member does not select a Health Network~~,~~ or CCN, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process, CalOptima shall assign such Member to a Health Network~~,~~ or CCN~~,~~ in accordance with the terms and conditions of this policy.

B. CalOptima shall ~~auto-assign~~Auto-Assign Members, in accordance with the provisions of this policy, to ensure the following:

1. Member access to health care services in geographic proximity to his or her residence, as on file with CalOptima from eligibility files received from the Department of Health Care Services (DHCS);

2. Community Health Center ~~Safety Net~~safety net provider participation in the CalOptima program; and

3. Member enrollment in Health Networks~~,~~ or CCN~~,~~ demonstrating quality performance.

C. Members may request to change their Health Network~~,~~ or CCN~~,~~ enrollment once per month, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

D. CalOptima shall ~~auto-assign~~Auto-Assign a Member who has not selected a Health Network~~,~~ or CCN~~,~~ to a Health Network~~,~~ or CCN~~,~~ by using available data from CalOptima or network providers or clinics indicating an existing relationship with a contracted provider or clinic to preserve the relationship where possible. In the absence of this information the Auto-Assign of a Member is

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based on a Zip Code Match between the Member's residence and a ~~HN~~Health Network/CCN's coverage area, as set forth in Section ~~II.E~~III.A.1.b. of this policy.

III. PROCEDURE

A. CalOptima shall ~~auto-assign~~Auto-Assign eligible Members to a Health Network~~,~~ or CCN~~,~~ as follows, and in the following order:

1. CalOptima shall ~~auto-assign~~Auto-Assign a Member to an existing contracted provider or clinic when provided with the data establishing the relationship by CalOptima or a network provider or clinic.

~~1.~~2. CalOptima shall Auto-Assign no less than thirty-seven percent (37%) of eligible Members to a Health Network~~,~~ or CCN~~,~~ based on the Member's assignment to a ~~Community Health Center~~community health center as a Primary Care Provider (PCP). CalOptima shall ~~auto-assign~~Auto-Assign Members through the Health Network~~,~~ or CCN~~,~~ level to the Community Health Center. If a new Federally Qualified Health Center (FQHC), or FQHC-Look-Alike, enters the CalOptima program, CalOptima shall increase the base Auto-Assignment allocation for Community Health Centers by one percent (1%), not to exceed forty-five percent (45%). If a FQHC, or FQHC-Look-Alike, terminates with the CalOptima program, CalOptima shall decrease the total Auto-Assignment allocation by one percent (1%), not to fall below thirty-seven percent (37%).

1. A Community Health Center shall select CCN~~,~~ or at least one (1) Health Network~~,~~ that shall receive its allocation of ~~auto-assigned~~Auto-Assigned Members. A Community Health Center may select CCN~~,~~ or one (1) Health Network~~,~~ that shall receive its allocation of pediatric ~~auto-assigned~~Auto-Assigned Members, and CCN~~,~~ or one (1) Health Network~~,~~ that shall receive its allocation of adult ~~auto-assigned~~Auto-Assigned Members.

   i. If a Community Health Center intends to select~~,~~ or unselect~~,~~ CCN~~,~~ or change the Health Network which shall receive its allocation of ~~auto-assigned~~Auto-Assigned Members, it shall notify CalOptima's Provider Relations Department, in writing.

   ii. If a Community Health Center fails to select CCN~~,~~ or at least one (1) Health Network~~,~~ that shall receive its allocation of ~~auto-assigned~~Auto-Assigned Members, CalOptima shall exclude that Community Health Center from receiving any allocation of ~~auto-assigned~~Auto-Assigned Members until a Health Network, or CCN, has been selected.

   iii. If the Community Health Center previously selected CCN~~,~~ or a Health Network~~,~~ that has been suspended for Auto-Assignment, the Community Health Center shall select an alternate Health Network~~,~~ or CCN~~,~~ to receive its allocation of ~~auto-assigned~~Auto-Assigned Members.

2. If a Member has a Zip Code Match with a Community Health Center's coverage area, CalOptima shall assign the Member to the Community Health Center as the Member's Primary Care ~~Physician~~Provider, in accordance with CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider.

3. CalOptima shall ~~auto-assign~~Auto-Assign Members to Community Health Centers based on performance metrics established in CalOptima Policy AA.1207c: Performance-based Community Health Center Auto-~~-~~Assignment Allocation Methodology.

4. A Health Network~~,~~ or CCN's~~,~~ receipt of ~~auto-assigned~~Auto-Assigned Members from a Community Health Center shall not affect the Health Network~~,~~ or CCN's~~,~~ receipt of any other ~~auto-assigned~~Auto-Assigned Members.

5. If CalOptima ~~auto-assigns~~Auto-Assigns a Member to a Community Health Center as the Member's PCP, the Member's Health Network~~,~~ or CCN~~,~~ shall not reassign such Member to a PCP that is not a Community Health Center unless the Member requests such reassignment.

~~2.~~3. CalOptima shall ~~auto-assign~~Auto-Assign eligible Members, not ~~auto-assigned under Section II.E of this policy~~Auto-Assigned to a Health Network~~,~~ or CCN. The Health Network~~,~~ or CCN~~,~~ shall assign a PCP to the Member.

1. CalOptima shall assign Members to a Health Network~~,~~ or CCN~~,~~ once it fills a Community Health Center's assignment allocation, or if there is no Zip Code Match between an eligible Member and a ~~Community Health Center's~~community health center's coverage area.

2. CalOptima shall ~~auto-assign~~Auto-Assign eligible Members to a Health Network~~,~~ or CCN~~,~~ based on the Health Network~~,~~ or CCN's~~,~~ score on the indicators listed in the Health Network~~,~~ or CCN~~,~~ Performance-based Auto Assignment Allocation Table, which shall be calculated pursuant to CalOptima Policy AA.1207b: Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology.

3. CalOptima shall assign any remaining Members to a Health Network with a Zip Code Match, regardless of whether or not that Health Network's Auto-Assignment allocation has been satisfied.

B. The number of ~~auto-assigned~~Auto-Assigned Members a Health Network~~,~~ or CCN~~,~~ receives may vary monthly, depending upon the number of Members eligible for Auto-Assignment and the Zip Code Match between a Member and a Health Network~~,~~ or CCN's~~,~~ coverage area.

C. In an effort to keep Members of the same family covered under one (1) Health Network~~,~~ or CCN, CalOptima shall ~~auto-assign~~Auto-Assign Members by family unit in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment. If a Family Linked Member who is less than twenty-one (21) years of age has family members in more than one (1) Health Network~~,~~ or CCN, CalOptima shall ~~auto-assign~~Auto-Assign such Family Linked Member to the same Health Network~~,~~ or CCN~~,~~ as his or her sibling.

1. If the Family Linked Member is known to be eligible with the Whole-Child Model (WCM) program/California Children Services Program (CCS) and the Family Linked Member's sibling is assigned to a Health Network that does not participate in the WCM program whether excluded from doing so or otherwise, the Family Linked Member shall be assigned to a Health Network participating in the WCM program.

D. Notwithstanding any other provisions of this policy~~,~~ and if applicable, subject to Section III.I., CalOptima shall assign a new Health Network ~~Eligible~~ eligible Member to CHOC Health Alliance if:

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1. The Member's parent, or guardian, fails to select a Health Network, or CCN, upon enrollment with CalOptima;

2. The Member will be less than seven (7) months of age at the time of enrollment with a Health Network~~,~~ or CCN;

3. The Member does not have another Family Linked Member enrolled in a ~~HN~~Health Network/CCN at the time of assignment; and

4. CHOC Health Alliance is not suspended from Auto-Assignment pursuant to this policy.

~~III.~~I. ~~PROCEDURE~~

E. ~~CalOptima~~ Notwithstanding any other provisions of this policy, CalOptima shall ensure, effective July 1, 2019, that CCS-eligible Members are not assigned, whether by Auto-Assignment or otherwise, to a Health Network that is excluded from participating in the WCM program.

F. An existing Member assigned to a Health Network who becomes CCS/WCM-eligible, or new CCS/WCM Members who do not select a Health Network, will be assigned to participating Health Networks after consideration of factors, unique to each Member, such as current PCP and specialist relationships to the Member, Members preference, provider and service utilization, diagnosis, severity of condition, Health Needs Assessment, geography, and language.

G. Effective July 1, 2019, if a new Member who is known to be CCS-eligible or an existing Member who becomes CCS-eligible (while enrolled in a Health network that does not participate in the WCM program) CalOptima's Auto-Assignment process will only allow a new CalOptima Member who is known to be CCS-eligible, to be assigned to a participating Health Network. All other existing Auto-Assignment rules will apply, including accounting for allotted percentages for the Health Networks.

H. Health Networks that do not meet the WCM network certification requirements can become eligible for the affected category of Auto-Assignment if they meet such requirements at a later date and are added to the WCM network with the approval of DHCS.

~~A.~~ Quality metrics and a minimum performance level on the established quality metrics shall be utilized to qualify for Auto Assignment. CalOptima may ~~impose penalties~~suspend Auto-Assignment against a Health Network~~,~~ or CCN~~,~~ if a Health Network~~,~~ or CCN~~,~~ fails to score at, or above, a specified performance ~~rate on a publicly reported~~level based on overall performance on established HEDIS ~~indicator.~~

~~E.~~I. ~~For publicly reported HEDIS performance~~ indicators ~~reported for the current measurement year, Health Networks are expected to score at the 50th percentile, or higher, based on the National Committee for Quality Assurance (NCQA) National Quality Compass benchmarks on at least two (2) of the clinical measures used to establish the Health Networks' Annual Quality performance.~~ .

~~1. For publicly reported HEDIS performance indicators reported for measurement year 2015, or later, CalOptima shall:~~

1. ~~Report~~ Achievement of minimum performance levels on quality metrics is assessed annually. A Health Network that has been suspended from Auto-Assignment due to failure to meet minimum performance levels will be reassessed annually. Auto-Assignment will be reinstated

when a Health Network has demonstrated that they meet the minimum performance levels established by CalOptima.

~~1.~~2. CalOptima shall report to the Audit & Oversight Committee (AOC) any Health Network that fails to ~~score a fifty percent (50%), or higher, performance rate on at least two (2) of the clinical measures used to establish the Health Network's Annual Quality performance.~~meet established minimum performance levels. CalOptima shall provide a written notice to any Health Network that fails to meet this threshold.

~~2.~~3. Pursuant to CalOptima Policy HH.~~2002Δ:~~2002Δ: Sanctions, CalOptima's ~~AOC~~Compliance Committee may impose penalties against a Health Network that fails to meet the minimum performance requirements.

~~3.~~4. Minimum Health Network performance ~~rates~~levels may be modified for future measurement years, pursuant to this policy. Any change in ~~rate~~performance level expectations shall be approved by the Quality Assurance Committee (QAC) of the Board of Directors prior to implementation. CalOptima shall notify Health Networks of the change prior to the ~~commencement of the measurement year.~~Implementation of changes to metrics or scoring of quality metrics. Notification to the networks includes discussion at Health Network Forum, Quality Forum, or other stakeholder forums that permit the Health Networks to be informed of planned changes to the quality metrics or scoring, and also permit them to provide feedback on the proposed changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207b: Performance-based Health Network and CalOptima Community Network Auto-Assignment Allocation Methodology
C. CalOptima Policy AA.1207c: Performance-based Community Health Center Auto- Assignment Allocation Methodology
D. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider
H. CalOptima Policy HH.~~2002A.~~2002Δ: Sanctions
I. Department of Health Care Services All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program
J. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care

~~V.~~VI. REGULATORY AGENCY APPROVAL(S)

None to Date

~~VI.~~VII. BOARD ACTION(S)

Date	Meeting
10/03/2006	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
02/05/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
11/01/2012	Regular Meeting of the CalOptima Board of Directors
12/06/2012	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

~~VII.~~VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	12/04/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/05/2008	AA.1207a	CalOptima Auto Assignment Policy	Medi-Cal
Revised	01/01/2011	AA.1207a	CalOptima Auto Assignment Policy	Medi-Cal
Revised	03/01/2011	AA.1207a	CalOptima Auto Assignment Policy	Medi-Cal
Revised	11/01/2012	AA.1207a	CalOptima Auto Assignment Policy	Medi-Cal
Revised	07/01/2013	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2016	AA.1207a	CalOptima Auto Assignment	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2017	AA.1207a	CalOptima Auto- Assignment	Medi-Cal
Revised	TBD	AA.1207a	CalOptima Auto-Assignment	Medi-Cal

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~~VIII.~~IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Provider and/or ~~to a~~ Health Network ~~or CalOptima Community Network~~.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. ~~1.~~ Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. ~~2.~~ Affiliated with a Health Network or CalOptima Direct; and 3. ~~3.~~ Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan	A plan delineating specific and identifiable activities or undertaking that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Healthcare Effectiveness Data and Information Set (HEDIS)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
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.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

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Term	Definition
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.
Zip Code Match	The DHCS reported member's home address zip code must match to a zip code within the zip code range table in order for that clinic or health network to be eligible for the Member assignment.

Policy:	AA.1207a
Title:	**CalOptima Auto-Assignment**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process by which CalOptima shall assign a Member who has not voluntarily selected a Health Network, or CalOptima Community Network (CCN), to a Health Network, or CCN.

II. POLICY

A. A Health Network-eligible Member shall select a Health Network or CCN in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process. If a Member does not select a Health Network or CCN, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process, CalOptima shall assign such Member to a Health Network or CCN in accordance with the terms and conditions of this policy.

B. CalOptima shall Auto-Assign Members, in accordance with the provisions of this policy, to ensure the following:

1. Member access to health care services in geographic proximity to his or her residence, as on file with CalOptima from eligibility files received from the Department of Health Care Services (DHCS);

2. Community Health Center safety net provider participation in the CalOptima program; and

3. Member enrollment in Health Networks or CCN demonstrating quality performance.

C. Members may request to change their Health Network or CCN enrollment once per month, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

D. CalOptima shall Auto-Assign a Member who has not selected a Health Network or CCN to a Health Network or CCN by using available data from CalOptima or network providers or clinics indicating an existing relationship with a contracted provider or clinic to preserve the relationship where possible. In the absence of this information the Auto-Assign of a Member is based on a Zip Code Match between the Member's residence and a Health Network/CCN's coverage area, as set forth in Section III.A.1.b. of this policy.

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III. PROCEDURE

A. CalOptima shall Auto-Assign eligible Members to a Health Network or CCN as follows, and in the following order:

1. CalOptima shall Auto-Assign a Member to an existing contracted provider or clinic when provided with the data establishing the relationship by CalOptima or a network provider or clinic.

2. CalOptima shall Auto-Assign no less than thirty-seven percent (37%) of eligible Members to a Health Network or CCN based on the Member's assignment to a community health center as a Primary Care Provider (PCP). CalOptima shall Auto-Assign Members through the Health Network or CCN level to the Community Health Center. If a new Federally Qualified Health Center (FQHC), or FQHC-Look-Alike, enters the CalOptima program, CalOptima shall increase the base Auto-Assignment allocation for Community Health Centers by one percent (1%), not to exceed forty-five percent (45%). If a FQHC, or FQHC-Look-Alike, terminates with the CalOptima program, CalOptima shall decrease the total Auto-Assignment allocation by one percent (1%), not to fall below thirty-seven percent (37%).

    1. A Community Health Center shall select CCN or at least one (1) Health Network that shall receive its allocation of Auto-Assigned Members. A Community Health Center may select CCN or one (1) Health Network that shall receive its allocation of pediatric Auto-Assigned Members, and CCN or one (1) Health Network that shall receive its allocation of adult Auto-Assigned Members.

        i. If a Community Health Center intends to select or unselect CCN or change the Health Network which shall receive its allocation of Auto-Assigned Members, it shall notify CalOptima's Provider Relations Department, in writing.

        ii. If a Community Health Center fails to select CCN or at least one (1) Health Network that shall receive its allocation of Auto-Assigned Members, CalOptima shall exclude that Community Health Center from receiving any allocation of Auto-Assigned Members until a Health Network, or CCN, has been selected.

        iii. If the Community Health Center previously selected CCN or a Health Network that has been suspended for Auto-Assignment, the Community Health Center shall select an alternate Health Network or CCN to receive its allocation of Auto-Assigned Members.

    2. If a Member has a Zip Code Match with a Community Health Center's coverage area, CalOptima shall assign the Member to the Community Health Center as the Member's Primary Care Provider, in accordance with CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider.

    3. CalOptima shall Auto-Assign Members to Community Health Centers based on performance metrics established in CalOptima Policy AA.1207c: Performance-based Community Health Center Auto-Assignment Allocation Methodology.

    4. A Health Network or CCN's receipt of Auto-Assigned Members from a Community Health Center shall not affect the Health Network or CCN's receipt of any other Auto-Assigned Members.

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5. If CalOptima Auto-Assigns a Member to a Community Health Center as the Member's PCP, the Member's Health Network or CCN shall not reassign such Member to a PCP that is not a Community Health Center unless the Member requests such reassignment.

3. CalOptima shall Auto-Assign eligible Members, not Auto-Assigned to a Health Network or CCN. The Health Network or CCN shall assign a PCP to the Member.

1. CalOptima shall assign Members to a Health Network or CCN once it fills a Community Health Center's assignment allocation, or if there is no Zip Code Match between an eligible Member and a community health center's coverage area.

2. CalOptima shall Auto-Assign eligible Members to a Health Network or CCN based on the Health Network or CCN's score on the indicators listed in the Health Network or CCN Performance-based Auto Assignment Allocation Table, which shall be calculated pursuant to CalOptima Policy AA.1207b: Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology.

3. CalOptima shall assign any remaining Members to a Health Network with a Zip Code Match, regardless of whether or not that Health Network's Auto-Assignment allocation has been satisfied.

B. The number of Auto-Assigned Members a Health Network or CCN receives may vary monthly, depending upon the number of Members eligible for Auto-Assignment and the Zip Code Match between a Member and a Health Network or CCN's coverage area.

C. In an effort to keep Members of the same family covered under one (1) Health Network or CCN, CalOptima shall Auto-Assign Members by family unit in accordance with CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment. If a Family Linked Member who is less than twenty-one (21) years of age has family members in more than one (1) Health Network or CCN, CalOptima shall Auto-Assign such Family Linked Member to the same Health Network or CCN as his or her sibling.

1. If the Family Linked Member is known to be eligible with the Whole-Child Model (WCM) program/California Children Services Program (CCS) and the Family Linked Member's sibling is assigned to a Health Network that does not participate in the WCM program whether excluded from doing so or otherwise, the Family Linked Member shall be assigned to a Health Network participating in the WCM program.

D. Notwithstanding any other provisions of this policy and if applicable, subject to Section III.I., CalOptima shall assign a new Health Network-eligible Member to CHOC Health Alliance if:

1. The Member's parent, or guardian, fails to select a Health Network, or CCN, upon enrollment with CalOptima;

2. The Member will be less than seven (7) months of age at the time of enrollment with a Health Network or CCN;

3. The Member does not have another Family Linked Member enrolled in a Health Network/CCN at the time of assignment; and

4. CHOC Health Alliance is not suspended from Auto-Assignment pursuant to this policy.

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E. Notwithstanding any other provisions of this policy, CalOptima shall ensure, effective July 1, 2019, that CCS-eligible Members are not assigned, whether by Auto-Assignment or otherwise, to a Health Network that is excluded from participating in the WCM program.

F. An existing Member assigned to a Health Network who becomes CCS/WCM-eligible, or new CCS/WCM Members who do not select a Health Network, will be assigned to participating Health Networks after consideration of factors, unique to each Member, such as current PCP and specialist relationships to the Member, Members preference, provider and service utilization, diagnosis, severity of condition, Health Needs Assessment, geography, and language.

G. Effective July 1, 2019, if a new Member who is known to be CCS-eligible or an existing Member who becomes CCS-eligible (while enrolled in a Health network that does not participate in the WCM program) CalOptima's Auto-Assignment process will only allow a new CalOptima Member who is known to be CCS-eligible, to be assigned to a participating Health Network. All other existing Auto-Assignment rules will apply, including accounting for allotted percentages for the Health Networks.

H. Health Networks that do not meet the WCM network certification requirements can become eligible for the affected category of Auto-Assignment if they meet such requirements at a later date and are added to the WCM network with the approval of DHCS.

I. Quality metrics and a minimum performance level on the established quality metrics shall be utilized to qualify for Auto Assignment. CalOptima may suspend Auto-Assignment against a Health Network or CCN if a Health Network or CCN fails to score at, or above, a specified performance level based on overall performance on established HEDIS indicators.

1. Achievement of minimum performance levels on quality metrics is assessed annually. A Health Network that has been suspended from Auto-Assignment due to failure to meet minimum performance levels will be reassessed annually. Auto-Assignment will be reinstated when a Health Network has demonstrated that they meet the minimum performance levels established by CalOptima.

2. CalOptima shall report to the Audit & Oversight Committee (AOC) any Health Network that fails to meet established minimum performance levels. CalOptima shall provide a written notice to any Health Network that fails to meet this threshold.

3. Pursuant to CalOptima Policy HH.2002Δ: Sanctions, CalOptima's Compliance Committee may impose penalties against a Health Network that fails to meet the minimum performance requirements.

4. Minimum Health Network performance levels may be modified for future measurement years, pursuant to this policy. Any change in performance level expectations shall be approved by the Quality Assurance Committee (QAC) of the Board of Directors prior to implementation. CalOptima shall notify Health Networks of the change prior to the Implementation of changes to metrics or scoring of quality metrics. Notification to the networks includes discussion at Health Network Forum, Quality Forum, or other stakeholder forums that permit the Health Networks to be informed of planned changes to the quality metrics or scoring, and also permit them to provide feedback on the proposed changes.

IV. ATTACHMENT(S)

Not Applicable

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V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207b: Performance-based Health Network and CalOptima Community Network Auto-Assignment Allocation Methodology
C. CalOptima Policy AA.1207c: Performance-based Community Health Center Auto Assignment Allocation Methodology
D. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
E. CalOptima Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider
H. CalOptima Policy HH.2002Δ: Sanctions
I. Department of Health Care Services All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program
J. Department of Health Care Services All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2006	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
02/05/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
11/01/2012	Regular Meeting of the CalOptima Board of Directors
12/06/2012	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	12/04/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/05/2008	AA.1207a	CalOptima Auto Assignment Policy	Medi-Cal
Revised	01/01/2011	AA.1207a	CalOptima Auto Assignment Policy	Medi-Cal
Revised	03/01/2011	AA.1207a	CalOptima Auto Assignment Policy	Medi-Cal
Revised	11/01/2012	AA.1207a	CalOptima Auto Assignment Policy	Medi-Cal
Revised	07/01/2013	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2016	AA.1207a	CalOptima Auto Assignment	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	TBD	AA.1207a	CalOptima Auto-Assignment	Medi-Cal

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IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Provider and/or Health Network.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network or CalOptima Direct; and 3. Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan	A plan delineating specific and identifiable activities or undertaking that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. Health Networks and Providers may be required to complete CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima policy, and other requirements identified by CalOptima and its regulators.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Healthcare Effectiveness Data and Information Set (HEDIS)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
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.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

Term	Definition
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.
Zip Code Match	The DHCS reported member's home address zip code must match to a zip code within the zip code range table in order for that clinic or health network to be eligible for the Member assignment.

Policy:	AA.1207b
Title:	**Performance-~~Based~~based Health Network and CalOptima Community Network Auto-Assignment Allocation Methodology**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima's methodology for determining a Health Network and CalOptima's Community Network's (CCN) Assignment allocations according to performance-based indicators.

II. POLICY

A. CalOptima shall ~~auto-assign~~Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CCN, to a Health Network, or CCN, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

B. CalOptima shall assign eligible Members not ~~auto-assigned~~Auto-Assigned under CalOptima Policy AA.1207a: CalOptima Auto-Assignment based on a Health Network's, or CCN's, performance-based Auto-Assignment allocation.

C. CalOptima shall determine a Health Network's, or CCN's, performance-based Auto-Assignment allocation according to indicators listed in the Health Network/CCN Performance-based Auto-Assignment Allocation Table.

1. Indicators listed in the Health Network/CCN Performance-based Auto-Assignment Allocation Table shall measure the following:

   a. Quality of clinical service; and

   ~~a. Administrative excellence.~~
   b. Member Experience

2. CalOptima shall assign each indicator a weight percent and score based on performance.

3. CalOptima shall calculate a Health Network's, ~~or~~(including CCN's~~,~~), performance-based Auto-Assignment allocation as follows:

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~~b. CalOptima shall consider a Health Network's, or CCN's, score on an indicator as a "raw score."~~

~~c. CalOptima shall divide the Health Network's, or CCN's, "raw score" by the total number of points scored by all Health Networks and CCN for that indicator, yielding the Health Network's, or CCN's, "relative score:"~~

~~*Relative score = (indicator raw score) / (total indicator raw score for all Health Network and CCN)*~~

~~d. CalOptima shall multiply a Health Network's, or CCN's, "relative score" by the weight percent assigned to the indicator to yield the "weighted score:"~~

~~*Weighted score = (relative score) x (weight percent for the indicator)*~~

~~e. A Health Network's, or CCN's, performance-based auto assignment allocation is equal to the sum of the Health Network's, or CCN's, "weighted score" for all indicators.~~

~~*Performance-based auto assignment allocation = Sum of weighted scores for all indicators*~~

~~CCN, or~~

a. CalOptima shall calculate a Health Network Quality Rating (HNQR) (scored between 1-5) for each Health Network. A higher score indicates better performance. The HNQR utilizes industry standard scoring developed by the National Committee for Quality Assurance to derive health plan quality performance scores. This methodology also aligns with CalOptima's Board of Directors approved Pay for Value program scoring methodology.

b. Health networks that do not achieve a HNQR of at least 2.5 will be suspended from Auto-Assignment until the next measurement period. Health Networks that do not achieve a HNQR of at least 2.5 will be notified and required to complete an improvement plan that details their plans to raise their performance to expected minimum performance levels.

c. Annually, each Health Network will be provided with documentation of how their HNQR score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the HNQR.

D. CCN, and each individual Health Network, shall be given a ~~rank. The Health Network, or CCN, rank is determined by the Health Network's, or CCN's, achieved "weighted score" in comparison to the achieved "weighted scores" of the other Health Networks, or CCN.~~ health network quality rating (HNQR) score from 1.0 to 5.0 based on their performance during the measurement period. CalOptima shall utilize the Health Network, or CCN, ~~rank~~HNQR, in numerical sequence, (highest to lowest) as the processing order for Auto-Assignments.

E. In the event that CCN's, or a Health Network's, Auto-Assignment is suspended for any reason, CalOptima shall distribute that Health Network's, or CCN's, allocation of ~~auto-assigned~~Auto-Assigned Members amongst the remaining eligible Health Networks, or CCN, in a manner that is proportional to each individual Health Network's, or CCN's, Performance-based Auto-Assignment allocation.

F. CalOptima shall score a Health Network for an indicator as long as the Health Network maintains a Contract for Health Care Services for the entire measurement year and is contracted with CalOptima at the time of measurement calculation~~.~~. Kaiser Permanente is excluded from Auto-Assignment.

G. Performance-based Auto-Assignment allocation for a new Health Network, or CCN:

~~2. CalOptima shall consider a Health Network, including CCN, as a~~A new Health Network for purposes of Auto-Assignment ~~for~~ is considered a Health Network with less than one (1) full measurement year~~.~~

1. ~~A new Health Network, including CCN, may receive partial points for an indicator if no~~ of data during the measurement period. New health networks will not be eligible for Auto-Assignment until the following year when a full year of data is available ~~for the indicator for the measurement year.~~and a HNQR can be calculated with evidence of minimum performance level achievement calculated by CalOptima staff.

   a. In the event of a declaration of a "extreme and uncontrollable event" declared by DHCS (such as the previous declarations for regional wild-fires and flooding which adversely impacted ability to collect data and calculate quality scores), there will be no penalties to scores and each HN will achieve at least a 2.5 HNQR.

H. CalOptima shall evaluate the performance-based Auto-Assignment allocation methodology for Health Networks and CCN annually, or upon:

1. Addition, or termination, of a Health Network;

2. A material change; or

3. Change in indicators.

I. CalOptima shall notify Health Networks of any changes in the performance-based Auto-Assignment allocation methodology, or indicators.

III. PROCEDURE

A. CalOptima shall measure each indicator annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following the measurement.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207a: CalOptima Auto-Assignment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/14/1995	Regular Meeting of the CalOptima Board of Directors
01/23/1996	Regular Meeting of the CalOptima Board of Directors
12/04/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2009	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2011	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	07/01/2013	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207b	Performance-Based Auto Assignment Allocation Methodology	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	AA.1207b	Performance-based Auto-Assignment Allocation Methodology	Medi-Cal

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IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Member who does not select a Primary Care Provider (PCP) and/or Health Network is assigned to a participating CalOptima Provider and/or Health Network.
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Health Network Eligible Member	A member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
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.

Policy:	AA.1207b
Title:	**Performance-based Health Network and CalOptima Community Network Auto-Assignment Allocation Methodology**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima's methodology for determining a Health Network and CalOptima's Community Network's (CCN) Assignment allocations according to performance-based indicators.

II. POLICY

A. CalOptima shall Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CCN, to a Health Network, or CCN, in accordance with CalOptima Policy AA.1207a: CalOptima Auto-Assignment.

B. CalOptima shall assign eligible Members not Auto-Assigned under CalOptima Policy AA.1207a: CalOptima Auto-Assignment based on a Health Network's, or CCN's, performance-based Auto-Assignment allocation.

C. CalOptima shall determine a Health Network's, or CCN's, performance-based Auto-Assignment allocation according to indicators listed in the Health Network/CCN Performance-based Auto-Assignment Allocation Table.

1. Indicators listed in the Health Network/CCN Performance-based Auto-Assignment Allocation Table shall measure the following:

    a. Quality of clinical service; and

    b. Member Experience

2. CalOptima shall assign each indicator a weight percent and score based on performance.

3. CalOptima shall calculate a Health Network's, (including CCN's), performance-based Auto-Assignment allocation as follows:

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a. CalOptima shall calculate a Health Network Quality Rating (HNQR) (scored between 1-5) for each Health Network. A higher score indicates better performance. The HNQR utilizes industry standard scoring developed by the National Committee for Quality Assurance to derive health plan quality performance scores. This methodology also aligns with CalOptima's Board of Directors approved Pay for Value program scoring methodology.

b. Health networks that do not achieve a HNQR of at least 2.5 will be suspended from Auto-Assignment until the next measurement period. Health Networks that do not achieve a HNQR of at least 2.5 will be notified and required to complete an improvement plan that details their plans to raise their performance to expected minimum performance levels.

c. Annually, each Health Network will be provided with documentation of how their HNQR score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the HNQR.

D. CCN, and each individual Health Network, shall be given a health network quality rating (HNQR) score from 1.0 to 5.0 based on their performance during the measurement period. CalOptima shall utilize the Health Network, or CCN, HNQR, in numerical sequence, (highest to lowest) as the processing order for Auto-Assignments.

E. In the event that CCN's, or a Health Network's, Auto-Assignment is suspended for any reason, CalOptima shall distribute that Health Network's, or CCN's, allocation of Auto-Assigned Members amongst the remaining eligible Health Networks, or CCN, in a manner that is proportional to each individual Health Network's, or CCN's, Performance-based Auto-Assignment allocation.

F. CalOptima shall score a Health Network for an indicator as long as the Health Network maintains a Contract for Health Care Services for the entire measurement year and is contracted with CalOptima at the time of measurement calculation. Kaiser Permanente is excluded from Auto-Assignment.

G. Performance-based Auto-Assignment allocation for a new Health Network, or CCN:

1. A new Health Network for purposes of Auto-Assignment is considered a Health Network with less than one (1) full measurement year of data during the measurement period. New health networks will not be eligible for Auto-Assignment until the following year when a full year of data is available and a HNQR can be calculated with evidence of minimum performance level achievement calculated by CalOptima staff.

a. In the event of a declaration of a "extreme and uncontrollable event" declared by DHCS (such as the previous declarations for regional wild-fires and flooding which adversely impacted ability to collect data and calculate quality scores), there will be no penalties to scores and each HN will achieve at least a 2.5 HNQR.

H. CalOptima shall evaluate the performance-based Auto-Assignment allocation methodology for Health Networks and CCN annually, or upon:

1. Addition, or termination, of a Health Network;

2. A material change; or

3. Change in indicators.

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I. CalOptima shall notify Health Networks of any changes in the performance-based Auto-Assignment allocation methodology, or indicators.

III. PROCEDURE

A. CalOptima shall measure each indicator annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following the measurement.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1207a: CalOptima Auto-Assignment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/14/1995	Regular Meeting of the CalOptima Board of Directors
01/23/1996	Regular Meeting of the CalOptima Board of Directors
12/04/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2009	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2011	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	07/01/2013	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2017	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207b	Performance-Based Auto Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207b	Performance-based Auto-Assignment Allocation Methodology	Medi-Cal

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IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Member who does not select a Primary Care Provider (PCP) and/or Health Network is assigned to a participating CalOptima Provider and/or Health Network.
CalOptima Community Network(CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
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.

Changes to Auto-Assignment Quality Metrics and Scoring

Quality Assurance Committee

September 14, 2022

Kelly Rex-Kimmet, Director, Quality Analytics

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Overview

- Auto-Assignment Policy
  - Overview of Policy
  - Performance Criteria
  - Performance Based Rating (current and proposed)
- Minimum Quality Score
- Next Steps

Auto-Assignment Policy Overview (cont.)

- On average ~7,000 Members are AA each month
  - Assignment is based on geographic zip code and performance-based criteria
  - Members can request to change their HN or CCN affiliation once per month
- Of the ~7,000 Members being AA:
  - 45% or ~3,150 are AA to the Community Health Centers
    - Each Community Health Center selects a HN or CCN affiliation in for its allocation of AA members
    - Currently, all Community Health Centers are affiliated with one or two HNs for their AA Members

Historical Quality Performance Criteria

Category	Indicator	Possible Points	Weight
Quality of Clinical Service	Well Child Visits: 3rd, 4th, 5th, 6th Years	0, 2, 5, 10	10%
	Adolescent Well-Care Visits	0, 2, 5, 10	10%
	HbA1c Testing/ Well Child Visit – 15 months	0, 2, 5, 10	10%
	Postpartum Care/ Childhood Immunization Combo 2	0, 2, 5, 10	10%
	Breast Cancer Screening/ Child Immunization MMR	0, 2, 5, 10	10%
	LDL Screening/ Appropriate Treatment Children URI	0, 2, 5, 10	10%
Administrative Excellence	Child Member Satisfaction Survey	0, 4, 10, 20	20%
	Encounters	0, 2, 5, 10	10%
	Auto-Assignment Retention Rate	0, 2, 5, 10	10%
	Total		100%

Proposed Changes to Auto-Assignment Quality Measures and Scoring

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CalOptima Health

Proposed New Performance Criteria

- Policy 1207.b describes quality based indicators for AA allocations
- The current quality-based indicators and scoring methodology is outdated
- Proposal: Adopt DHCS Managed Care Accountability Set minimum performance measures to replace existing quality performance measure set. This aligns with current Pay for Value (P4V) Program
  - Goal: Move away from a “home grown” scoring system and adopt a nationally established and tested quality scoring system.
  - Alignment with P4V program aligns providers to consistently focus their improvement efforts removing confusion about separate measures for different programs

Proposed New Auto-Assignment Quality Metrics and Gate

- Minimum Quality Score (Quality Gate) based on Health Network Quality Rating (HNQR) must be achieved annually to be eligible to receive auto-assignment.
- Proposed Minimum Overall HNQR score=2.5 out of 5
  - Effective 2022, based on Measurement Year (MY) 2021 performance)
  - Corrective action plan issued to HNs below 2.5
  - HNs who do not meet minimum quality score of 2.5 will be suspended from AA for one year until their quality score is above minimum performance level.
  - Higher overall HNQR scores earns higher percentage of AA
- No proposed change to HN vs. Community Health Center distribution. (55% HN, 45% Community Health Center)
- Scoring and auto-assignment allocation remains annual.

Health Network Quality Rating (HNQR)-Overall rating*

Health Network	HNQR 2020	HNQR 2021
AltaMed	3.5	4.5
AMVI Care	3.0	4.0
CCN	3.0	3.5
CHOC	4.0	4.5
Family Choice	2.5	3.0
Heritage-Regal	2.5	3.5
Kaiser	4.5	4.5
Noble	2.5	3.5
OPTUM-Arta	3.0	3.0
OPTUM-Monarch	2.5	3.5
OPTUM-Talbert	2.5	4.0
Prospect	2.5	3.5
UCMG	2.5	3.5

11 of 13 health networks improved compared to prior year

- Overall rating includes points for HEDIS & member experience scores
- Kaiser is excluded from auto-assignment

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2022 DHCS Comprehensive Quality Strategy

Quality Assurance Committee

September 14, 2022

Marsha Choo, Director, Quality Improvement

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DHCS 2022 Comprehensive Quality Strategy (CQS) Background

- Ten-year quality vision to improve quality of life and eliminate health disparities
- Integrates a whole-system, person-centered and population health approach to care
- Building partnerships with Medi-Cal members and organizations in the community implement this vision
- Focus on three target clinical areas:
  - Children's preventive care
  - Behavioral health integration
  - Maternal care

DHCS = Department of Health Care Services

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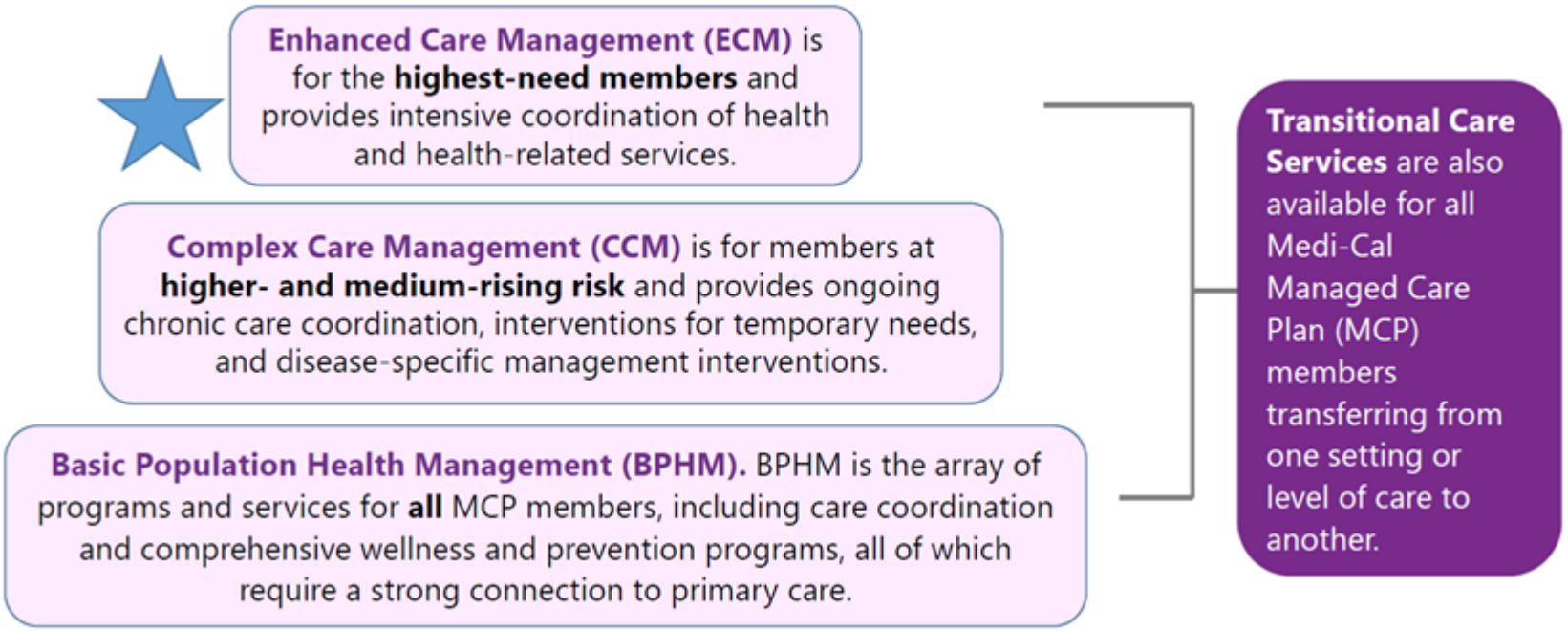
CalOptima Health

DHCS 2022 Comprehensive Quality Strategy (CQS) Background (cont.)

- Establishes a CalAIM Population Health Management (PHM) Strategy to address member needs across the continuum of care



Source: Population Health Management (PHM) Strategy and Roadmap, 2022

CalAIM = California Advancing and Innovation Medi-Cal

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CalOptima Health

CQS: Goals and Guiding Principles

Source: Department of Health Care Services Comprehensive Quality Strategy, 2022

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CalOptima Health

CQS: Performance - Bold Goals 50x2025

- Ambitious performance clinical goals and health equity outcomes
- Close disparities by 50% and achieve 50th percentile by year 2025
- Emphasizes health equity for clinical areas of focus

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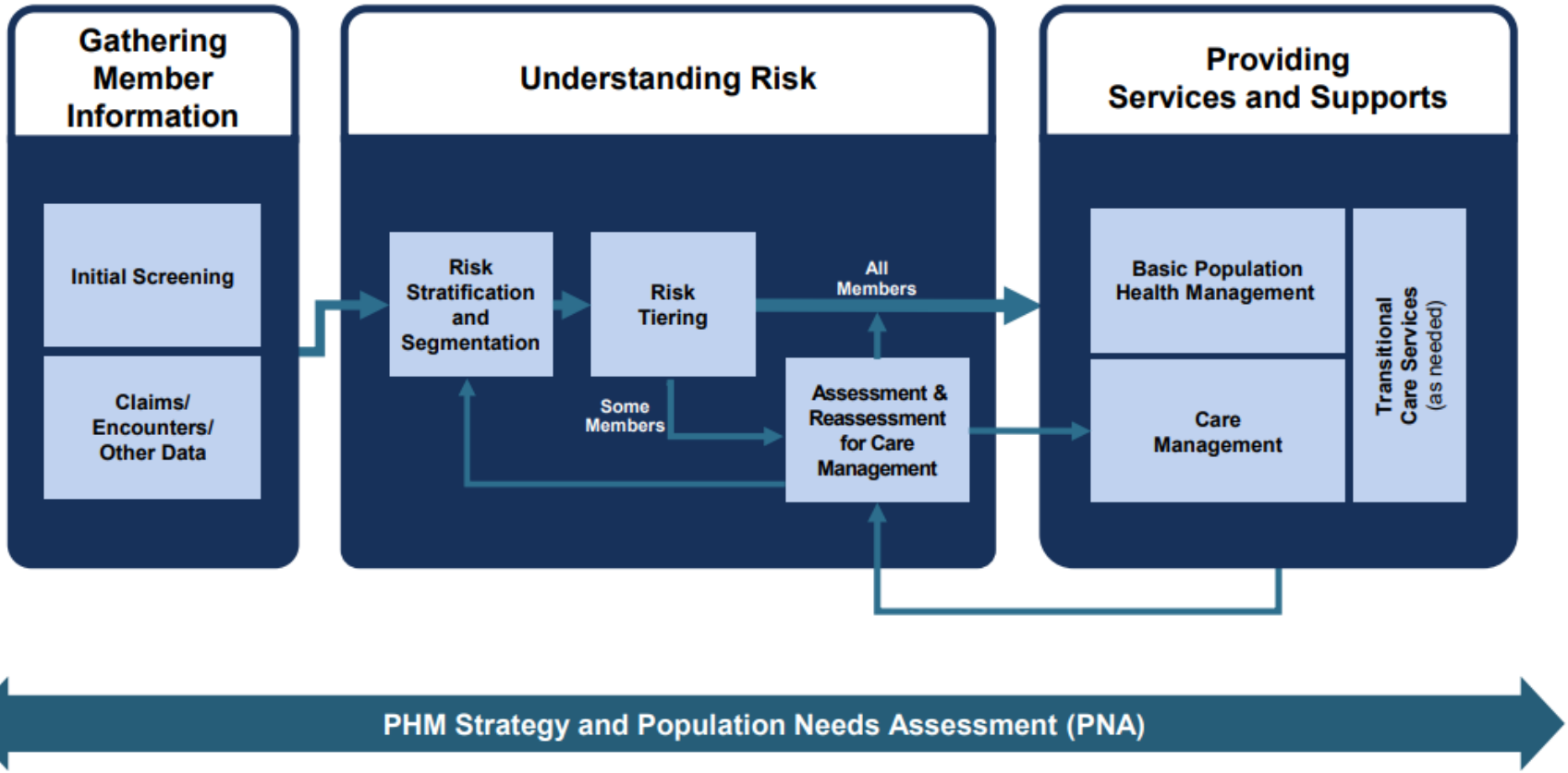
CQS: Population Health Management (PHM) Framework



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CQS: Highlights

- DHCS quality strategy will:
  - Increase benefits to support Health Equity
  - Expand Medi-Cal eligibility to all undocumented residents younger than age 26 and older than age 50
  - Implement a centralized data source
  - Have one standard contract for all Managed Care Plans
  - Implement Value Base Payments (provider incentives) for multiple measures
  - Establish ambitious performance goals
  - Require plans to achieve National Committee for Quality Assurance (NCQA) Health Equity Accreditation, in addition to Health Plan Accreditation

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CalOptima Health

Next Steps

- Continue to implement CalAIM
- Explore Health Equity Accreditation
- Incorporate elements of the DHCS CQS into the QI Work Plan, when appropriate
- DHCS released final Population Health Management Strategy (PHM) and Roadmap in July 2022
  - Align CalOptima's PHM Strategy with DHCS PHM Strategy and Roadmap
- Meet DHCS requirement for the broad range of programs and services by January 2023

https://www.dhcs.ca.gov/services/Documents/DHCS-Comprehensive-Quality-Strategy-2022.pdf

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HEDIS® Measurement Year (MY) 2021 Results

Quality Assurance Committee
September 14, 2022

Kelly Rex-Kimmet, Director, Quality Analytics

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How we utilize HEDIS results

- Department of Health Care Services (DHCS)
  - Managed Care Accountability Set (MCAS) — select measures must achieve minimum performance level (MPL), which is the national Medicaid 50th percentile
  - Financial sanctions or corrective action plans may be imposed for measures that do not meet the MPL
- National Committee for Quality Assurance (NCQA)
  - Health Plan Ratings (HPR)
  - Accreditation
- Centers for Medicare & Medicaid Services (CMS)
  - Star Ratings
  - Quality withhold payment

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CalOptima Health

COVID-19 Public Health Emergency (PHE)

- In 2021, the COVID-19 PHE continued throughout the year. This is the second year of rates impacted by the PHE.
- While the COVID-19 pandemic is improving, it still negatively impacts the utilization of health care services.
- Members are still missing important preventive care services.
- Some rates for all lines of business still show a drop in performance compared to previous years
- The impact of the COVID-19 PHE on rates must be kept in mind as rates are reviewed
  - Individual measure rates and trending are in the appendix

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CalOptima Health

Medi-Cal Summary

- Overall, rates in MY2021 are recovering from COVID-19 PHE but not at the pre-COVID level yet
  - ⇧ Childhood immunization, Cervical cancer screening, Asthma treatment, Cardiovascular disease treatment, HbA1c control, Antidepressant Medications Management are improved
  - ⇩ Weight Assessment, Breast cancer screening, Appropriate Testing for Pharyngitis, and Follow-up After ED visit for Mental Illness are reduced
- Only one measure did not achieve the MPL set by DHCS:
  - Well Child Visits (a new measure this year)
  - Financial sanction or improvement plan may be required by DHCS
- NCQA Health Plan Rating (HPR) — projected to maintain a 4.0 out of 5.0 rating
  - 4.0 score=Top Medicaid plan designation

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CalOptima Health

Top Opportunities for Improvement: Medi-Cal

- Measure that did not meet the MPL
  - Well Child Visits
- Controlling High-Blood Pressure
  - Triple weighted in Health Plan Rating set
  - Telehealth visits often did not document a BP
  - Home BP monitors an initiative under consideration

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CalOptima Health

Medicare Summary

- OneCare rates in MY2021 are recovering from MY2020 impacted by the COVID-19 PHE
  - ↑ Colorectal Cancer Screening, Comprehensive Diabetes Care, Care for Older Adults are improved
  - ↓ Breast Cancer Screening, Controlling High-Blood Pressure are lower than prior year
- OneCare Connect rates in MY2021 still have negative impact from the COVID-19 PHE
  - ↑ Readmissions within 30 days rates are improved
  - ↓ Follow-up After Hospitalization for Mental Illness, Controlling High-Blood Pressure are lower than prior year
  - Two measures did not meet the Quality withhold benchmarks
    - Controlling High-Blood Pressure
    - Follow-up After Hospitalization for Mental Illness (30-day)

+ Star Rating cut-off values are based on 2022 Star Tech Notes updated 10/4/2021

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CalOptima Health

Top Opportunities: Medicare

- Controlling blood pressure
  - Will be weighted 3X in MY2022
  - CBP rate was negatively impacted due to lack of BPs found in provider medical records
  - Telehealth visits do not record BP unless a member has a home BP device and reports BP during telehealth visit
- Transitions of Care
  - Notifications of Admission and Discharges
    - Lack of discharge summaries in Medical charts. No follow up visit documented within 30 days
  - Medication reconciliation
    - Opportunity to leverage medication review summaries from our Care Management system.

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CalOptima Health

Health Network Quality Rating (HNQR) HEDIS Results Only MY2020 vs. MY2021Comparison

Health Network	HNQR 2020	HNQR 2021
AltaMed	4.0	4.5
AMVI Care	4.0	4.5
CCN	3.0	4.0
CHOC	4.0	4.5
Family Choice	3.0	3.5
Heritage-Regal	3.0	3.5
Kaiser	4.5	5.0
Noble	3.0	3.5
OPTUM-Arta	3.0	3.5
OPTUM-Monarch	3.0	3.5
OPTUM-Talbert	3.0	4.0
Prospect	3.0	3.5
UCMG	3.0	3.5

HNQR is scored 1.0-5.0. Higher score is better

All HN HEDIS HNQR improved compared to prior year

Results based on P4V measure performance

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CalOptima Health

Health Network Quality Rating (HNQR)-Overall rating*

Health Network	HNQR 2020	HNQR 2021
AltaMed	3.5	4.5
AMVI Care	3.0	4.0
CCN	3.0	3.5
CHOC	4.0	4.5
Family Choice	2.5	3.0
Heritage-Regal	2.5	3.5
Kaiser	4.5	4.5
Noble	2.5	3.5
OPTUM-Arta	3.0	3.0
OPTUM-Monarch	2.5	3.5
OPTUM-Talbert	2.5	4.0
Prospect	2.5	3.5
UCMG	2.5	3.5

HNQR is scored 1.0-5.0. Higher score is better

11 of 13 health networks improved compared to prior year

* Overall rating includes points for HEDIS & member experience scores

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CalOptima Health

Looking to the future

- Performance Measurement is Evolving
  - DHCS Quality Strategy
  - NCQA focus on health disparities and Health Equity Accreditation
  - DMHC Health Equity Measures
- New measures require access to expanded types of data sources including Social Determinants Of Health (SDOH), race/ethnicity, hospital admit and discharge data.

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CalOptima Health

Looking to the future (cont.)

- NCQA Goal: All HEDIS measures digital in 5 years
  - Obtaining proof of service in a paper medical record will no longer be permitted and EMR data exchange becomes critical
- Investment in our ability to exchange data with EMR systems and infrastructure to support EMR data exchange will be needed to meet the evolving needs of quality performance measurement requirements.
- Need to expand electronic access to new data sources to capture SDOH, hospital ED, admit and discharge data.

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HEDIS® Measurement Year (MY) 2021 Results Appendix

Quality Assurance Committee
September 14, 2022

Kelly Rex-Kimmet, Director, Quality Analytics

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Appendix

HEDIS MY2021 Measure Rates and Trending

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Medi-Cal Measure Three Year Trended Results

National Medicaid MY 2020 Percentiles: NCQA Quality Compass

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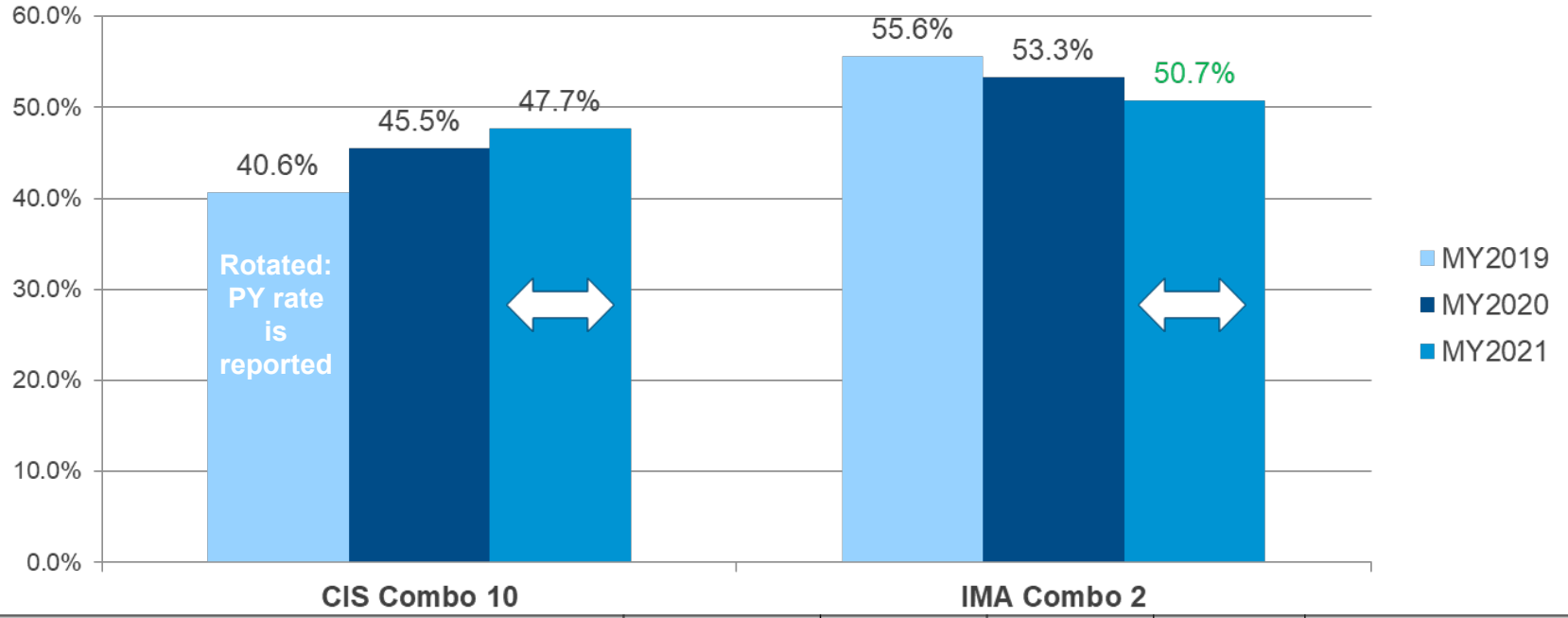
Pediatric Prevention Measures

HEDIS MY2021 Results: Medi-Cal Immunizations



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Childhood Immunization Status (CIS) - combo10 ++	33.33%	42.34%	53.66%	49.58%	HPR, MPL, P4V
Immunizations for Adolescents (IMA) - Combo 2++	33.52%	41.81%	50.61%	50.61%	HPR, MPL, P4V

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value**

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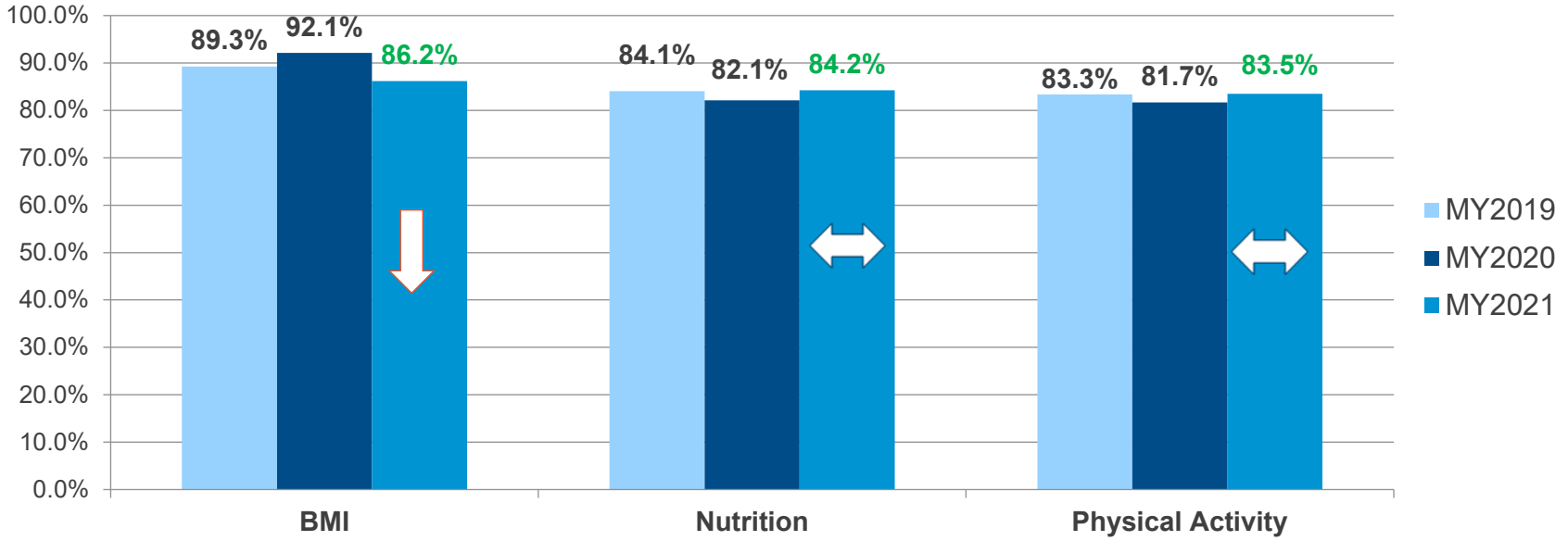
HEDIS MY2021 Results: Medi-Cal Weight Assessment and Counseling



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements* *
BMI Percentile (WCC)	69.19%	76.64%	82.73%	82.73%	HPR, MPL, P4V
Counseling for Nutrition (WCC)	64.23%	74.21%	82.48%	82.48%	MPL, P4V
Counseling for Physical Activity (WCC)	60.00%	71.34%	79.32%	79.32%	MPL, P4V

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value**

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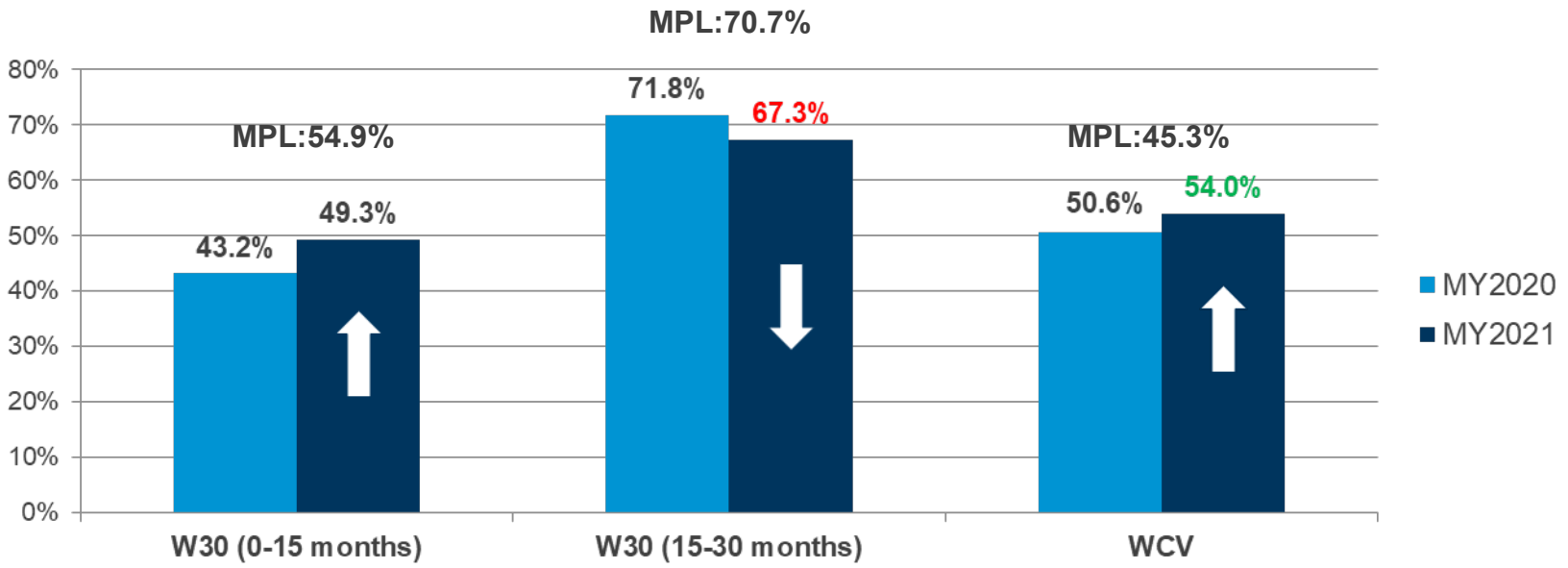
HEDIS MY2021 Results: Medi-Cal Well Visits



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements* *
Well-Child Visits in the First 30 Months of Life (W30) 0-15 months	48.90%	58.96%	68.33%	54.92%	MPL, P4V
Well-Child Visits in the First 30 Months of Life (W30) 15-30 months	67.38%	74.42%	82.82%	74.42%	MPL, P4V
Child and Adolescent Well-Care Visits Total (WCV)	41.38%	50.58%	61.97%	53.83%	MPL, P4V

*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

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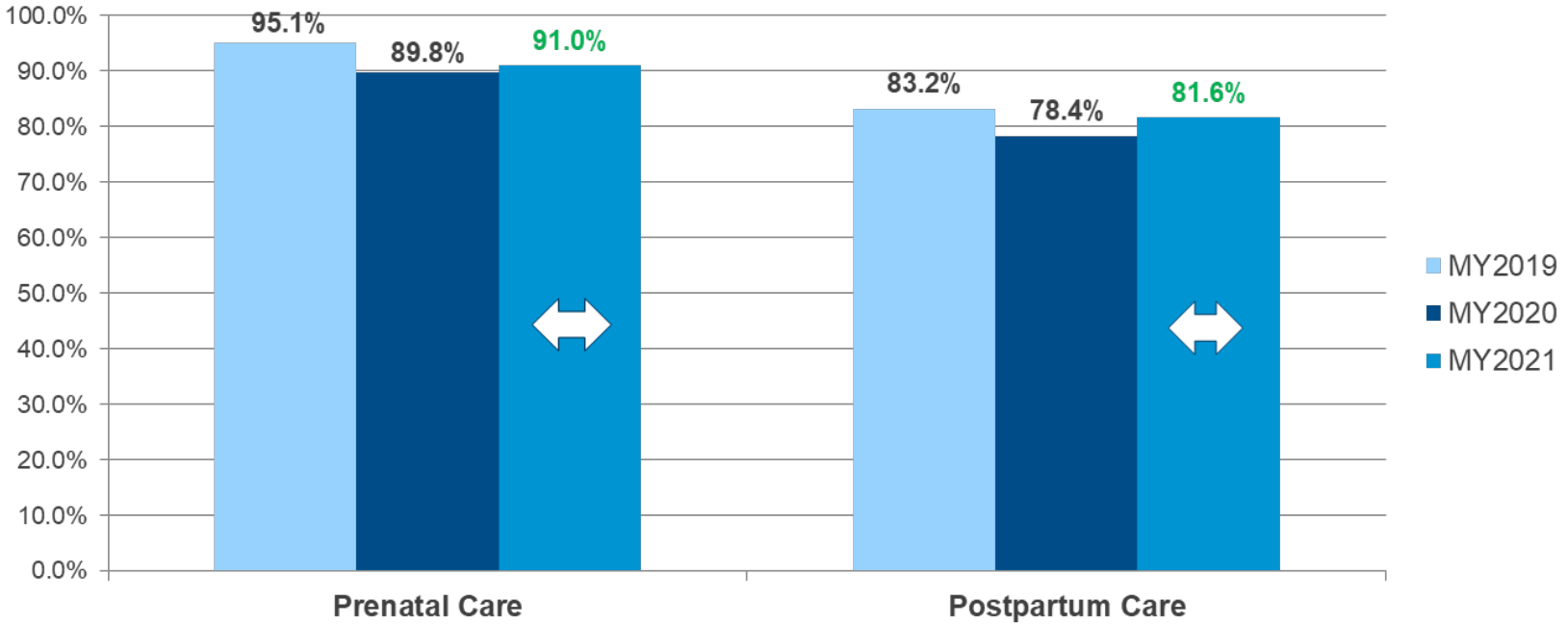
CalOptima Health

Prevention: Women's Reproductive Health

HEDIS MY2021 Results: Medi-Cal Prenatal and Postpartum Care



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	81.51%	88.32%	92.21%	90.75%	HPR, MPL, P4V
Postpartum Care	73.72%	78.35%	83.70%	79.56%	HPR, MPL, P4V

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value**

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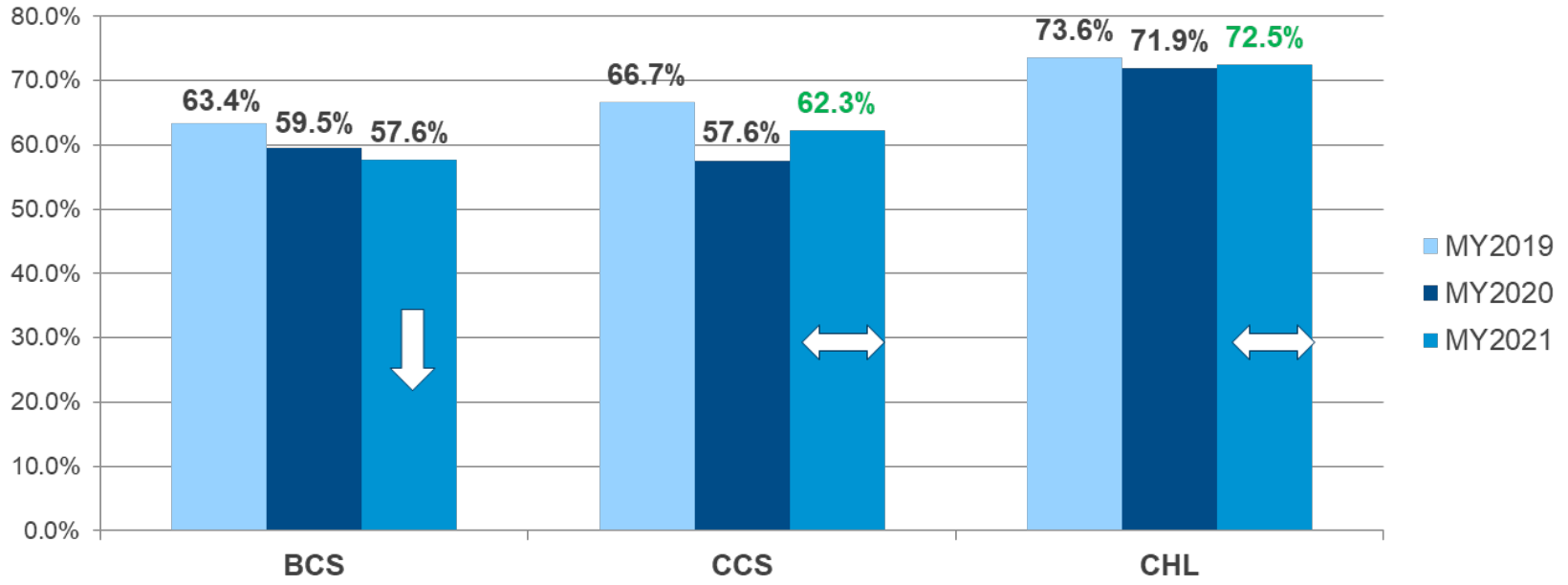
CalOptima Health

Prevention:
Cancer Screening

HEDIS MY2021 Results: Medi-Cal Women's Health Cancer Screenings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Breast Cancer Screening (BCS)	51.20%	56.72%	63.77%	61.24%	HPR, MPL, P4V
Cervical Cancer Screening (CCS)	54.01%	61.80%	67.99%	59.12%	HPR, MPL, P4V
Chlamydia Screening in Women (CHL)	50.76%	60.28%	66.15%	66.15%	MPL, P4V

*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

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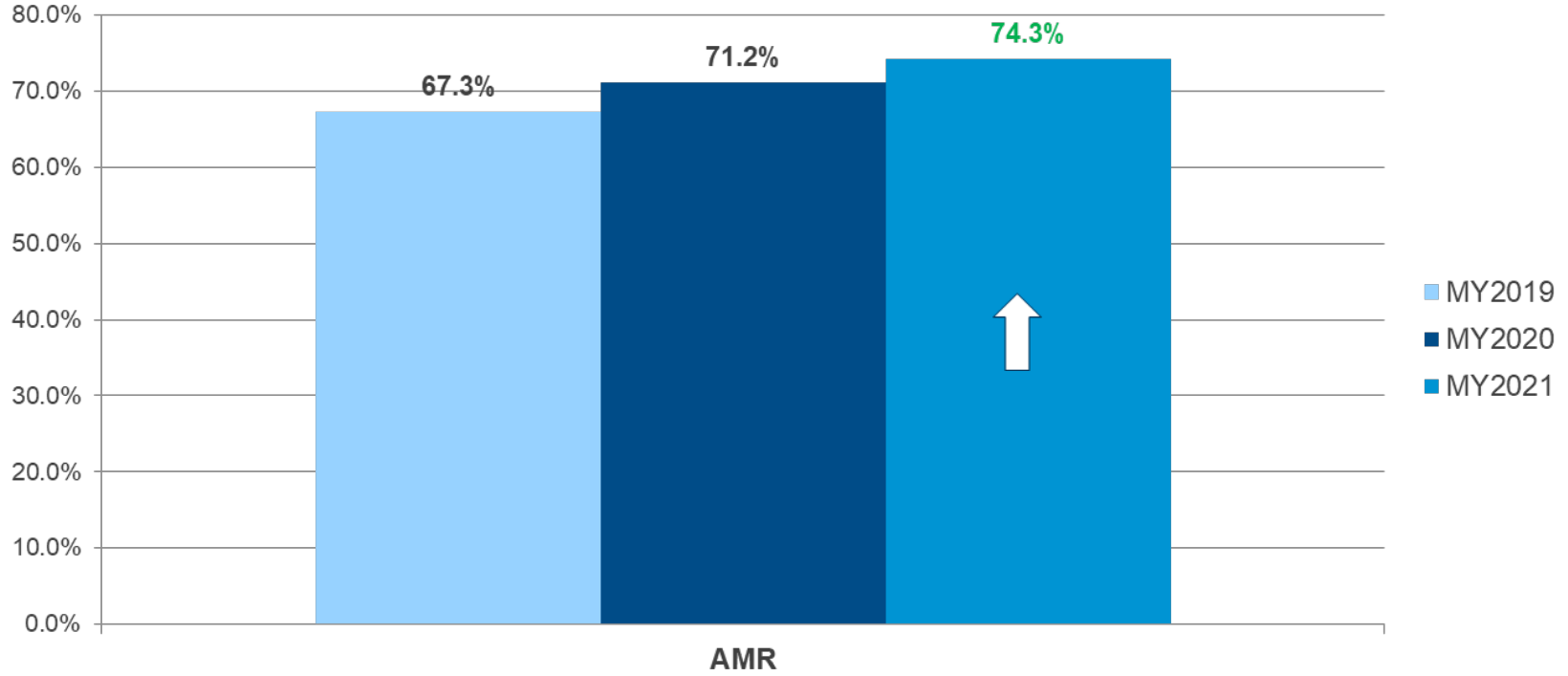
Treatment: Respiratory Conditions

HEDIS MY2021 Results: Medi-Cal Asthma Treatment



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements* *
Asthma Medication Ratio >50% (AMR) 5 to 64 years	62.26%	68.24%	75.32%	73.00%	HPR

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings**

↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

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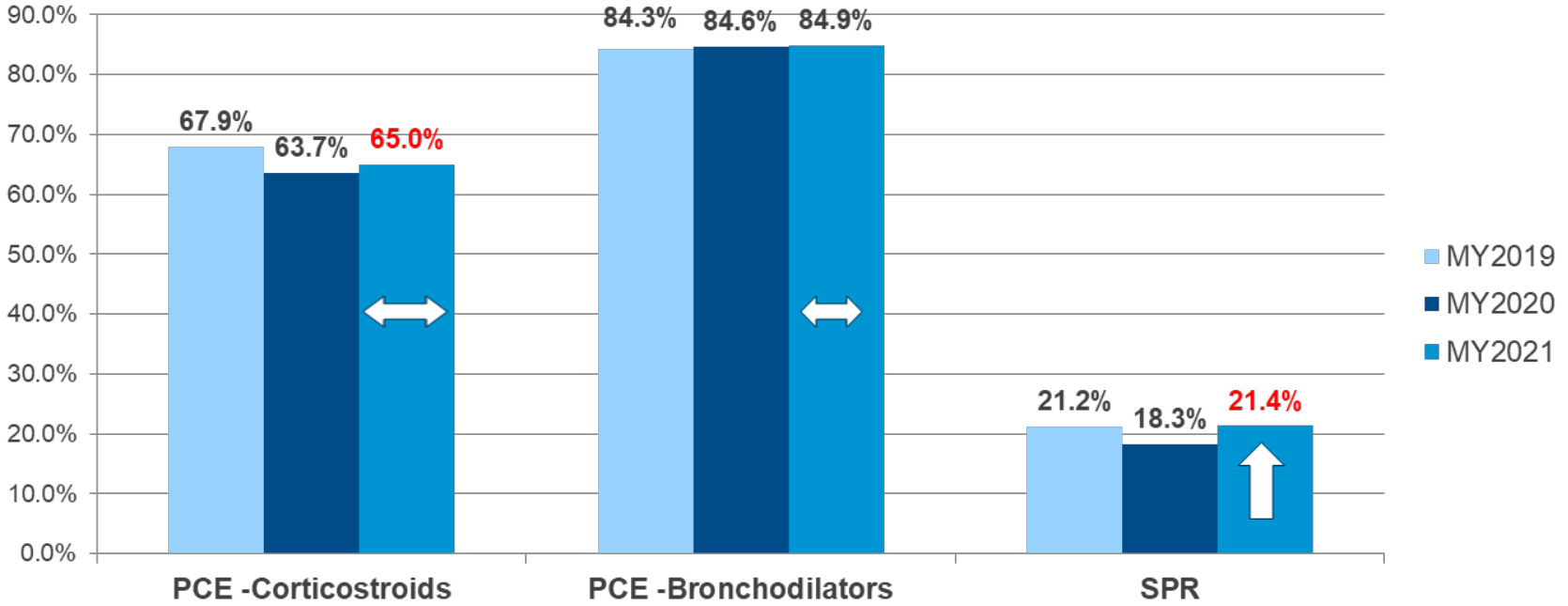
CalOptima Health

HEDIS MY2021 Results: Medi-Cal COPD

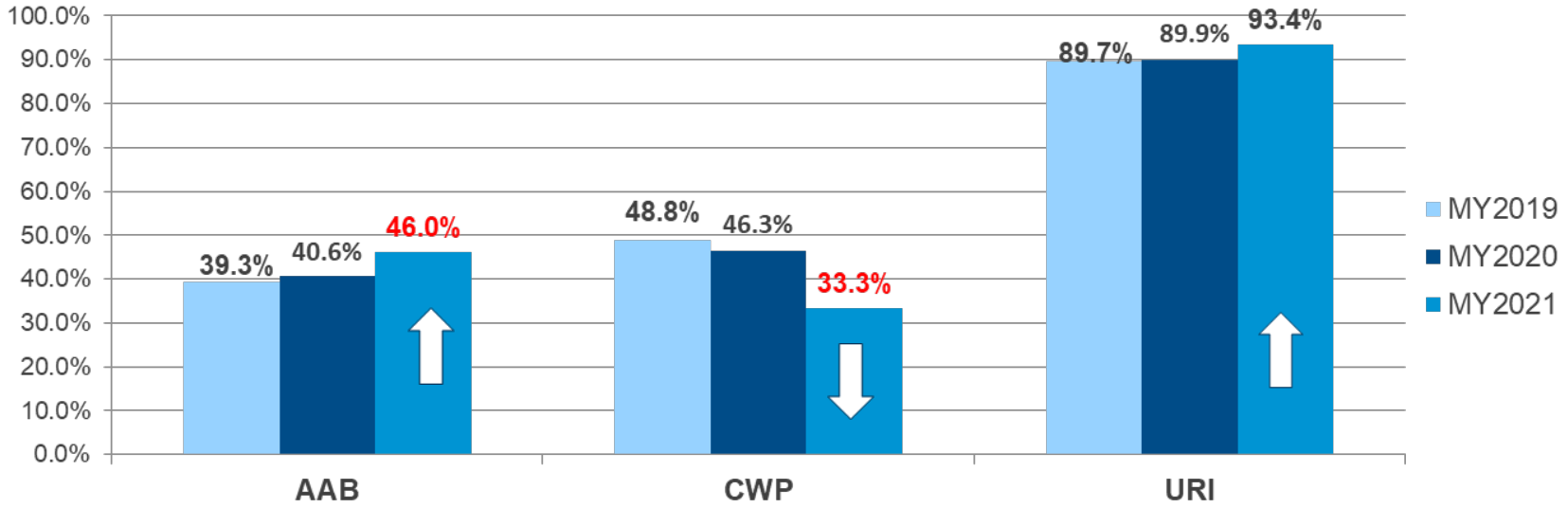


HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Pharmacotherapy Management of COPD Exacerbation (PCE) - Systemic Corticosteroids	66.67%	73.66%	80.84%	70.33%	HPR
Pharmacotherapy Management of COPD Exacerbation (PCE) - Bronchodilators	82.47%	86.99%	90.57%	85.08%	HPR
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	23.86%	29.03%	35.29%	22.27%	

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings**

↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

HEDIS MY2021 Results: Medi-Cal Respiratory Conditions



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	49.46%	59.51%	70.39%	47.62%	HPR
Appropriate Testing for Children with Pharyngitis (CWP)	72.98%	80.59%	85.77%	69.71%	HPR
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	86.88%	90.81%	94.34%	90.81%	HPR

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value**

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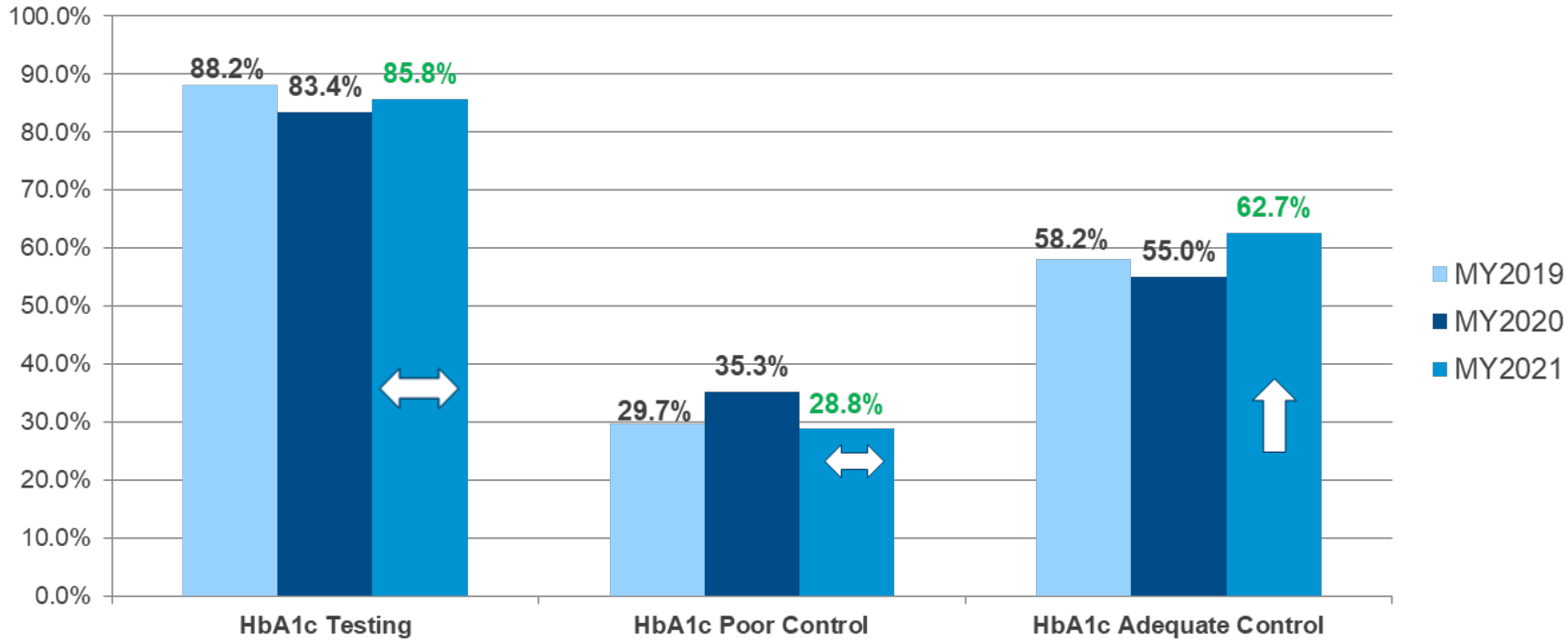
Treatment: Diabetes

HEDIS MY2021 Results: Medi-Cal Comprehensive Diabetes Care – HbA1c



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
HbA1c Testing	81.27%	85.16%	88.08%	85.16%	
HbA1c Poor Control (>9.0%) (Lower is better)	48.18%	39.66%	34.06%	34.06%	MPL, P4V
HbA1c Adequate Control (<8.0%) ++	42.09%	49.64%	55.23%	55.23%	HPR

*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

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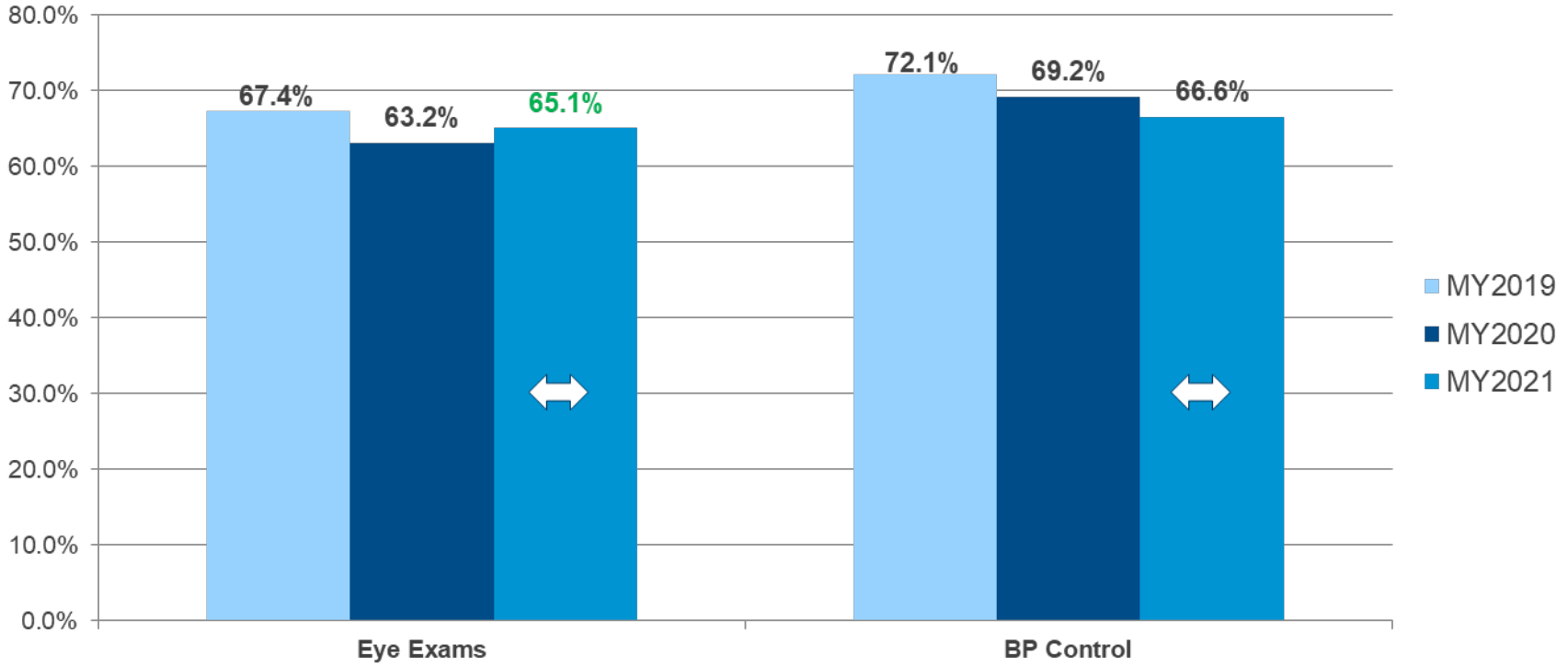
HEDIS MY2021 Results: Medi-Cal Comprehensive Diabetes Care



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Eye Exams	46.96%	55.96%	63.02%	63.02%	HPR
BP Control (<140/90) ++	54.26%	63.26%	71.23%	71.23%	HPR

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value**

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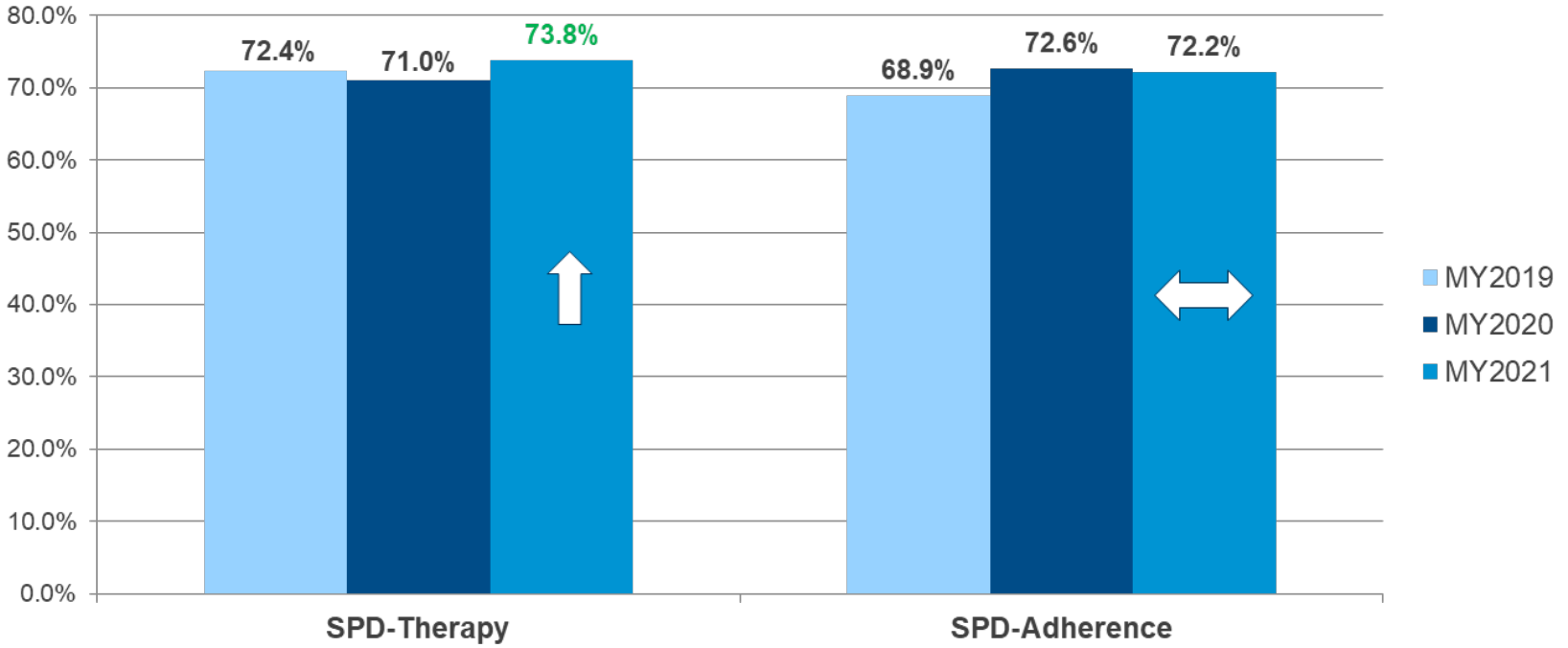
HEDIS MY2021 Results: Medi-Cal Diabetes Conditions



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) - therapy	63.47%	68.57%	72.23%	72.23%	HPR
Statin Therapy for Patients with Diabetes (SPD) - adherence	64.95%	71.95%	80.00%	73.43%	HPR

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value**

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Treatment: Cardiovascular Conditions

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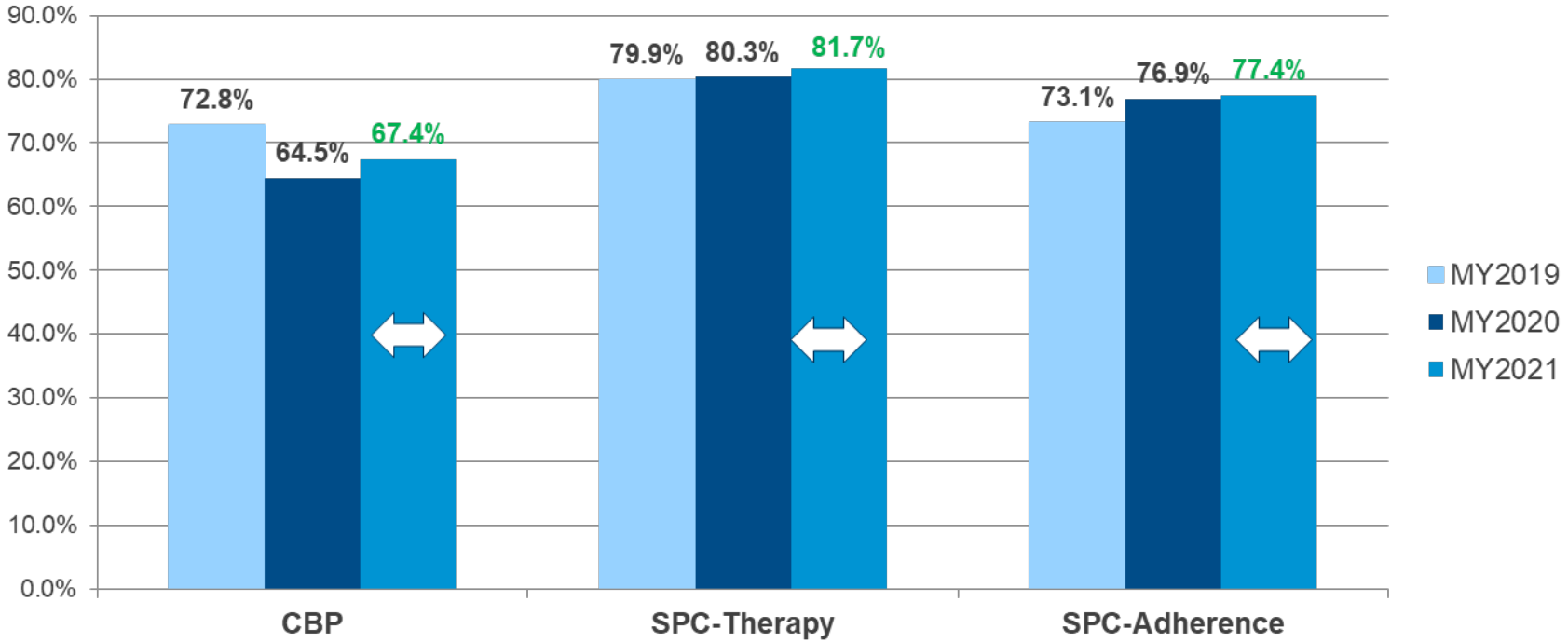
HEDIS MY2021 Results: Medi-Cal Cardiovascular Conditions



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Controlling High-Blood Pressure (CBP) ++	52.31%	60.10%	66.79%	64.66%	HPR, MPL, P4V
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Therapy	78.67%	81.90%	85.64%	80.34%	HPR
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Adherence	68.27%	74.98%	81.31%	76.98%	HPR

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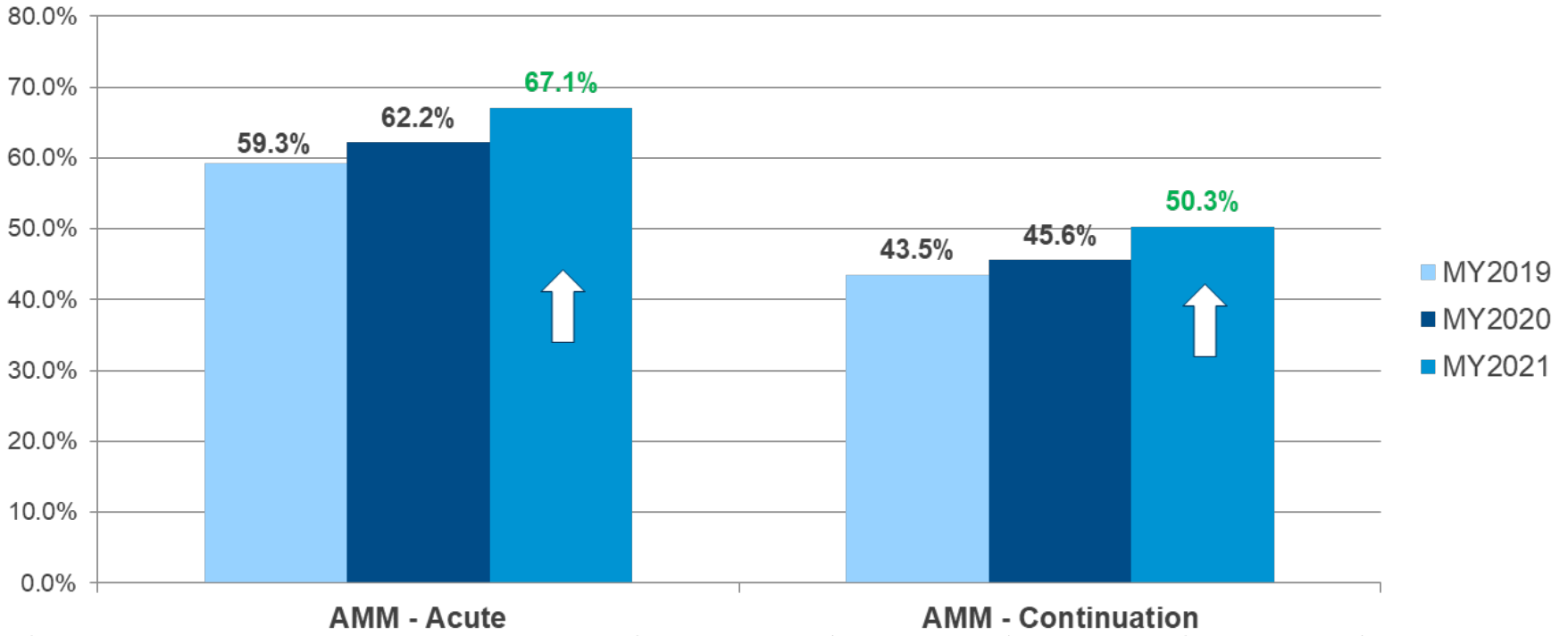
Treatment: Behavioral Health

HEDIS MY2021 Results: Medi-Cal

Behavioral Health– Antidepressant Medication Management



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Antidepressant Medications Management (AMM) - Acute Phase Treatment	53.49%	59.20%	67.74%	64.79%	MPL, P4V
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	38.50%	42.97%	52.49%	45.61%	HPR, MPL, P4V

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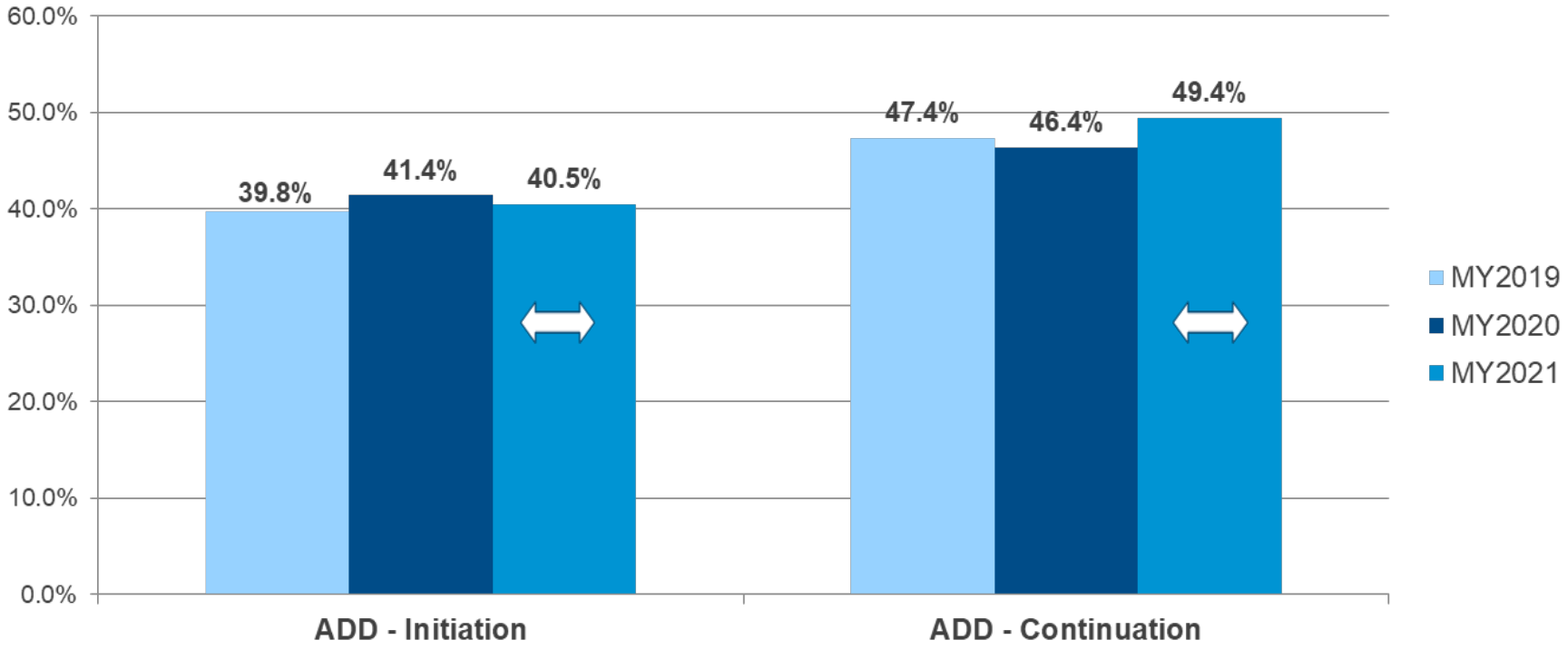
HEDIS MY2021 Results: Medi-Cal
Behavioral Health – Attention Deficit Disorder



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	40.17%	47.74%	55.99%	44.51%	
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	48.92%	60.35%	67.61%	55.96%	HPR

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value**

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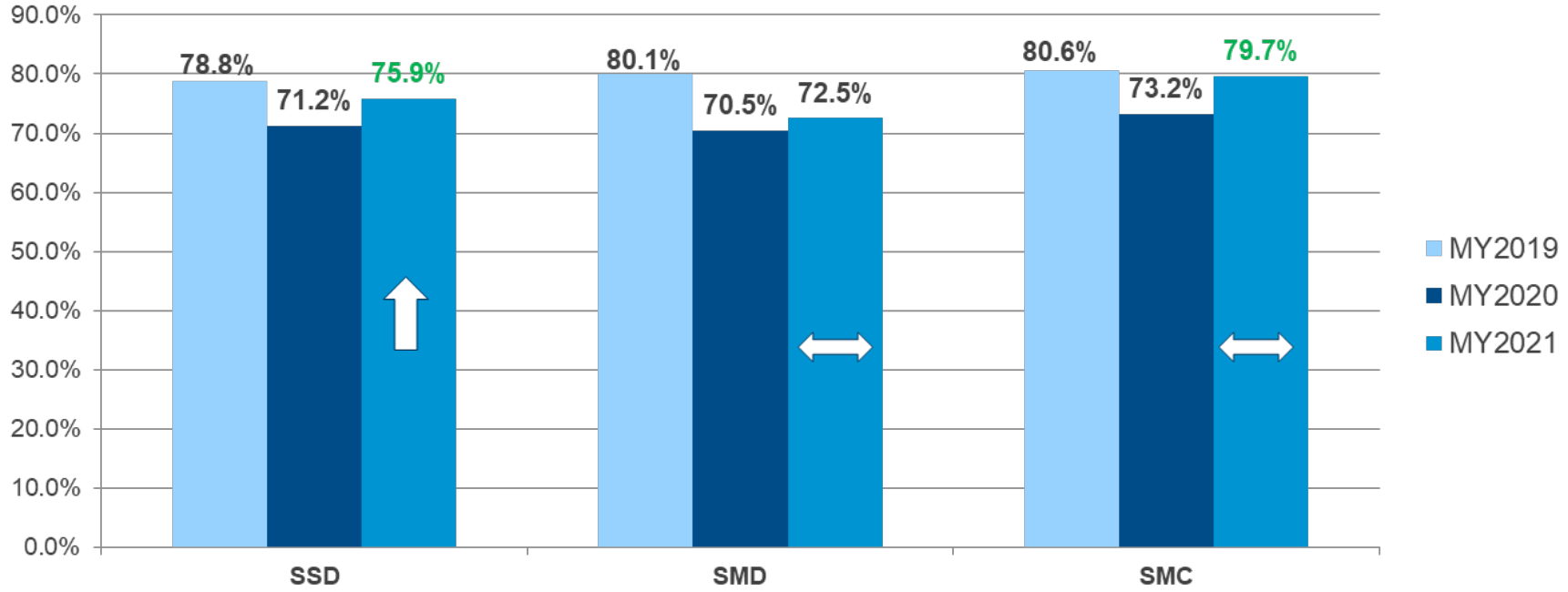
HEDIS MY2021 Results: Medi-Cal

Behavioral Health- Schizophrenia or Bipolar Disorder



HEDIS Measure	QC 33rd Percentile	QC 66h Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications (SSD)	74.94%	78.90%	82.53%	73.69%	HPR
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	61.61%	68.84%	75.00%	72.71%	
Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia (SMC)	69.77%	76.19%	83.67%	73.43%	

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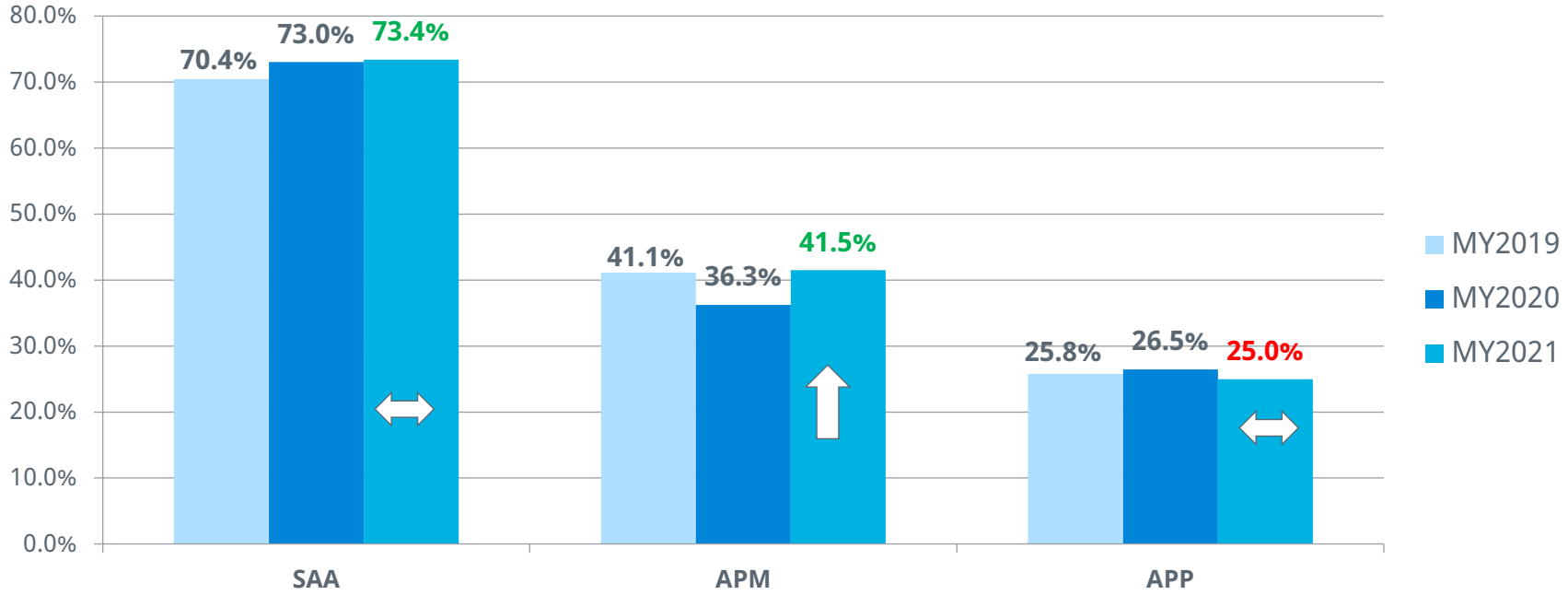
HEDIS MY2021 Results: Medi-Cal
Behavioral Health - Antipsychotic Medications



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	59.25%	67.62%	73.04%	73.04%	HPR
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	26.04%	34.89%	44.58%	36.84%	HPR
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	57.67%	66.87%	76.29%	52.91%	HPR

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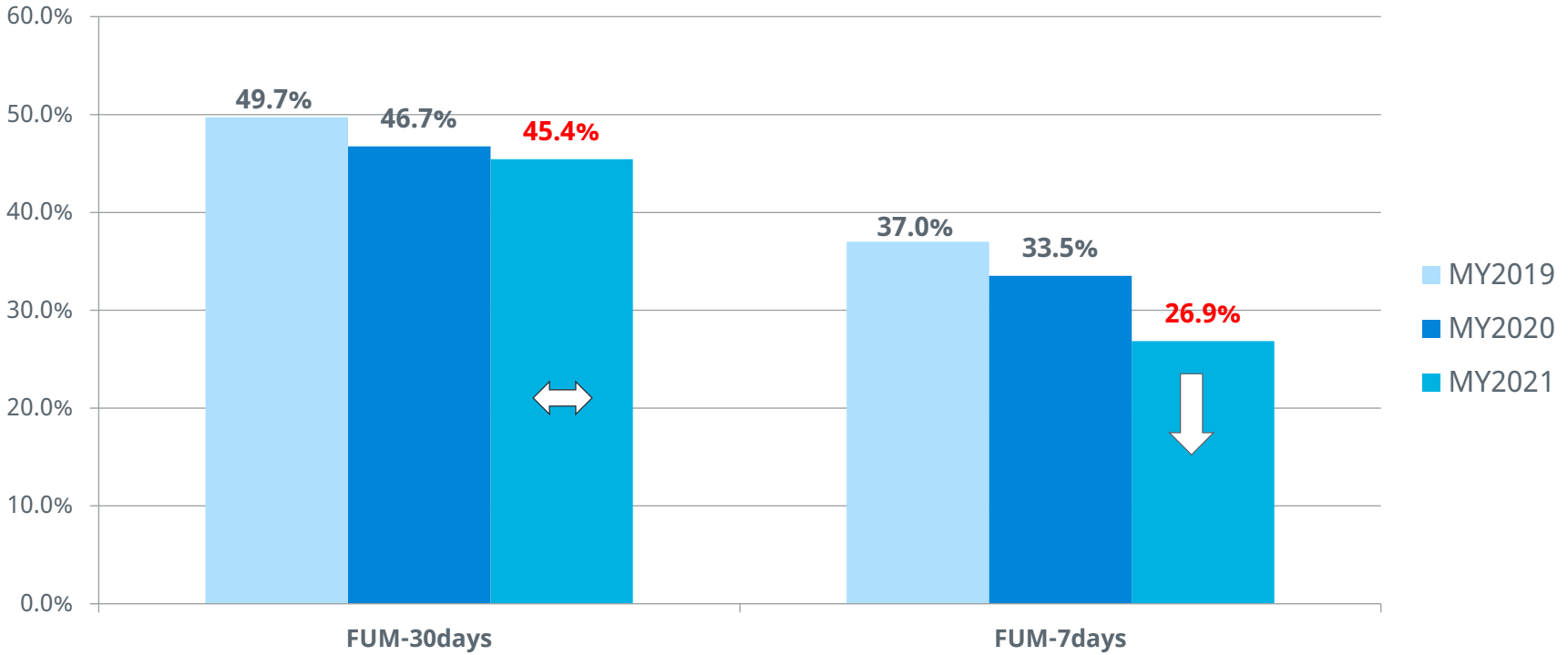
HEDIS MY2021 Results: Medi-Cal
Behavioral Health – Follow-up after ED Visits



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-up After ED visit for Mental Illness (FUM 30-day)	48.41%	60.94%	74.39%	53.54%	
Follow-up After ED visit for Mental Illness (FUM 7-day)	32.49%	46.38%	61.36%	38.55%	HPR

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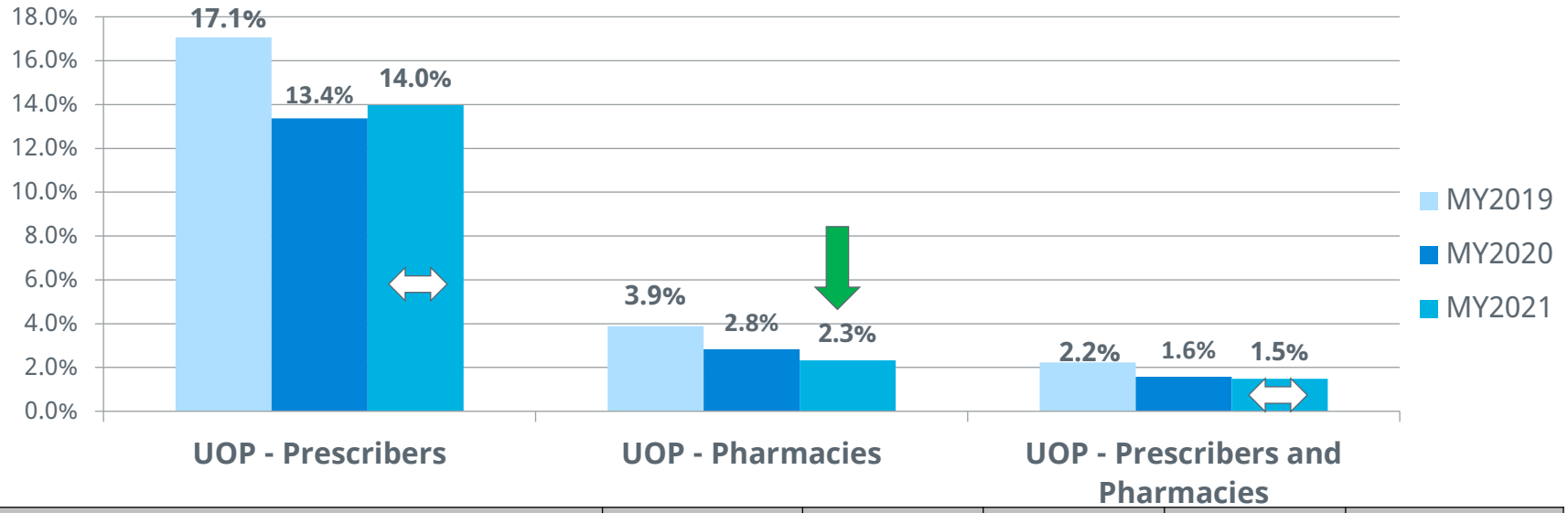
Opioid Use and Treatment

HEDIS MY2021 Results: Medi-Cal Use of Opioids



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Use of Opioids From Multiple Providers (UOP) - multiple Prescribers	20.92%	16.48%	12.23%	12.23%	
Use of Opioids From Multiple Providers (UOP) - multiple Pharmacies	4.03%	2.07%	1.09%	2.07%	
Use of Opioids From Multiple Providers (UOP) - multiple Prescribers and Pharmacies	2.47%	1.21%	0.52%	1.21%	HPR

***Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value**

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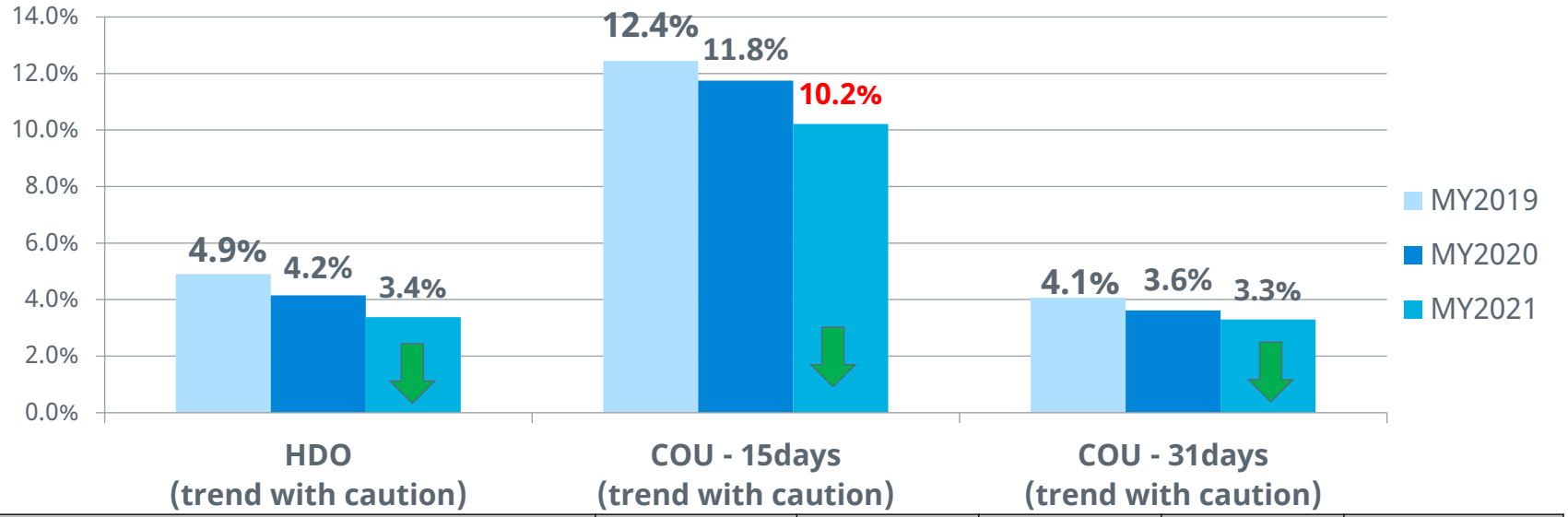
HEDIS MY2021 Results: Medi-Cal Use of Opioids



HEDIS Measure (Lower rate is better)	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Use of Opioids at High Dosage (HDO)	7.42%	2.87%	1.18%	2.87%	HPR
Risk of Continued Opioid Use - 15 days (COU)	8.16%	4.72%	2.68%	9.57%	
Risk of Continued Opioid Use - 31 days (COU)	4.55%	2.79%	1.52%	2.79%	HPR

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DHCS MCAS: Non-HEDIS Measures (CMS Core Set Measures)

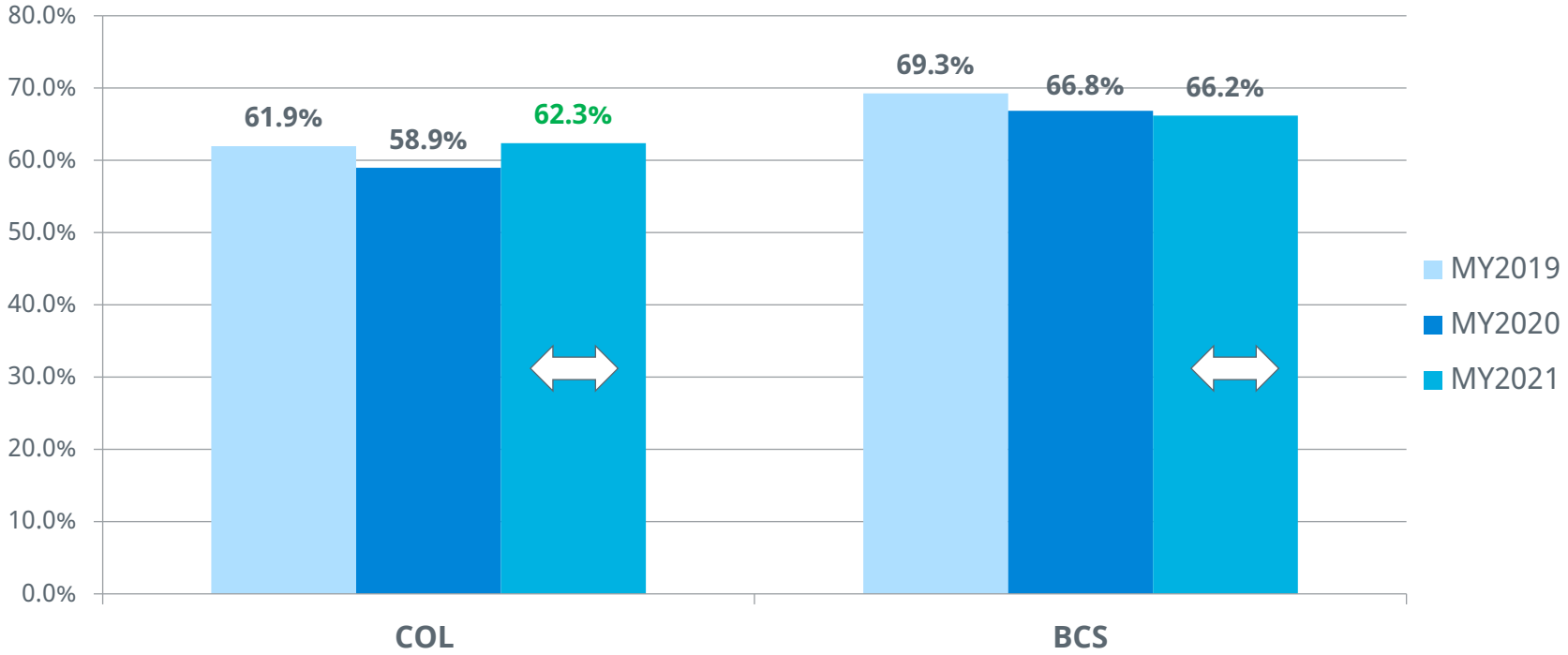
HEDIS MY2021 Results: MCAS Audited Non-HEDIS (no benchmarks)

Measure	MY2020 Rate	MY2021 Rate
Contraceptive Care All Women Ages 15-44 (Most or moderately effective contraception)	19.4%	19.5%
Contraceptive Care All Women Ages 15-44 (Acting Reversible contraception)	3.0%	3.1%
Contraceptive Care Postpartum Women Ages 15-44 (Most or moderately effective contraception 3 days)	7.6%	6.5%
Contraceptive Care Postpartum Women Ages 15-44 (Acting Reversible contraception 3 days)	3.0%	2.7%
Contraceptive Care Postpartum Women Ages 15-44 (Most or moderately effective contraception 60 days)	31.7%	28.9%
Contraceptive Care Postpartum Women Ages 15-44 (Acting Reversible contraception 60 days)	9.4%	9.6%
Developmental Screening in the First Three Years of Life	24.8%	31.2%
Concurrent Use of Opioids and Benzodiazepines	13.8%	12.8%
Use of Opioids at High Dosage in Persons Without Cancer	4.8%	4.0%
Screening for Depression and Follow-Up Plan: Ages 12 and Older	16.3%	17.7%

OneCare (OC) Results

Benchmarks — NCQA National Medicare HEDIS MY 2020 Percentiles and CMS Medicare 2022 Part C & D Star Ratings Technical Notes 10/04/2021 Update

HEDIS MY2021 Results: OneCare Prevention and Screening



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements**
Colorectal Cancer Screening (COL)	62%	71%	80%	62%	Star
Breast Cancer Screening (BCS)	61%	69%	76%	69%	Star

***Red = less than 3-Star or 33rd percentile, Green= met the goal** ****Star cut points are previous year**
↑ ↓ statistically higher or lower ↔ statistically no difference

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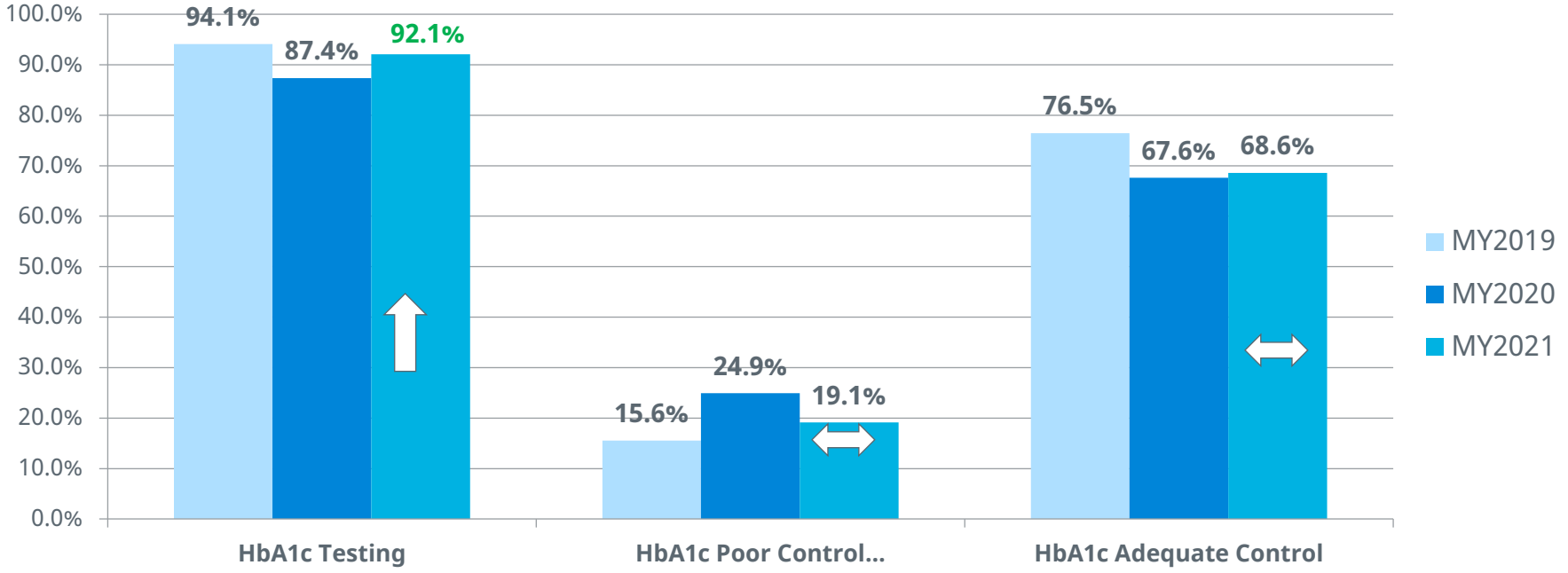
HEDIS MY2021 Results: OneCare
Comprehensive Diabetes Care – HbA1c



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - HbA1c Testing	90.65%	93.92%	96.11%	89.18%	CMS
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%) #	40%	28%	19%	19%	Star
Comprehensive Diabetes Care (CDC) - HbA1c Adequate Control (<8.0%)	59.38%	69.80%	75.88%	69.80%	CMS

***Red = less than 3-Star or 33rd percentile, Green= met goal **Star cut points are previous year**
↑ ↓ statistically higher or lower ↔ statistically no difference

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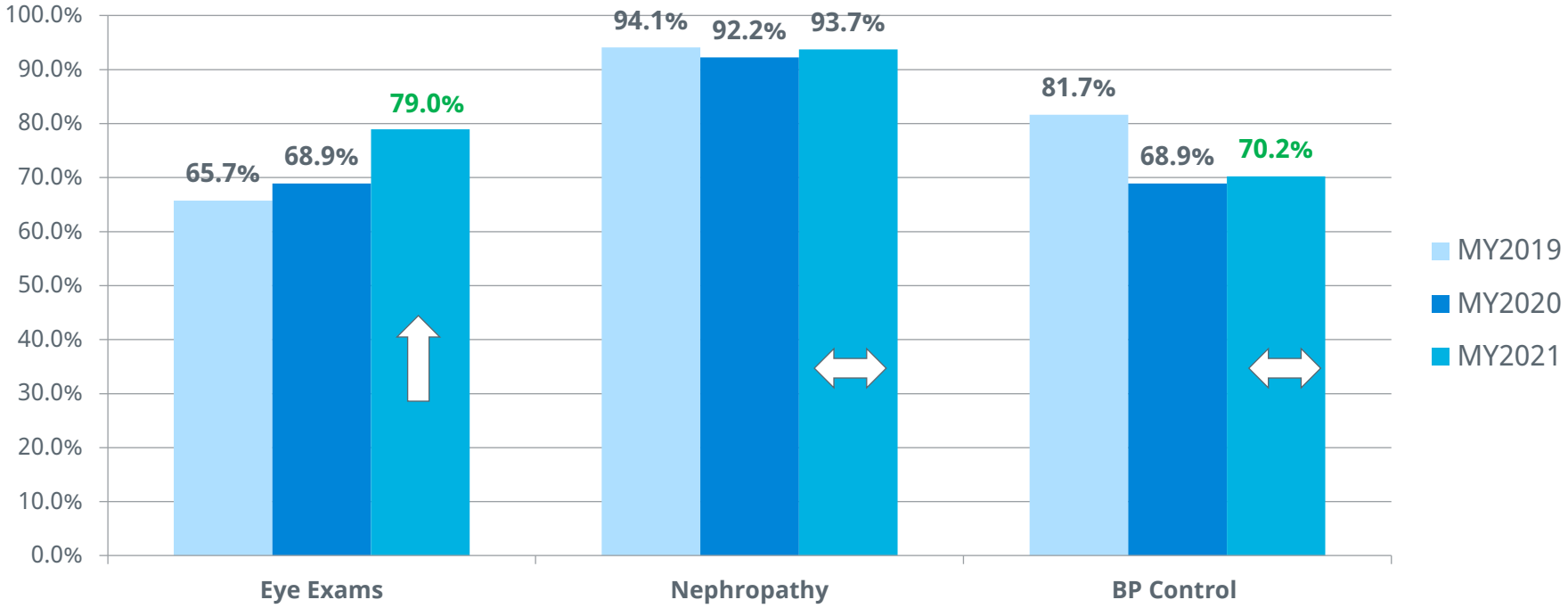
HEDIS MY2021 Results: OneCare Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - Eye Exams	62%	71%	79%	71%	Star
Comprehensive Diabetes Care (CDC) - Nephropathy Monitoring	88%	94%	97%	94%	Star
Comprehensive Diabetes Care (CDC) - BP Control (<140/90)	61.68%	69.53%	77.86%	69.53%	CMS

***Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year**

↑ ↓ statistically higher or lower ↔ statistically no difference

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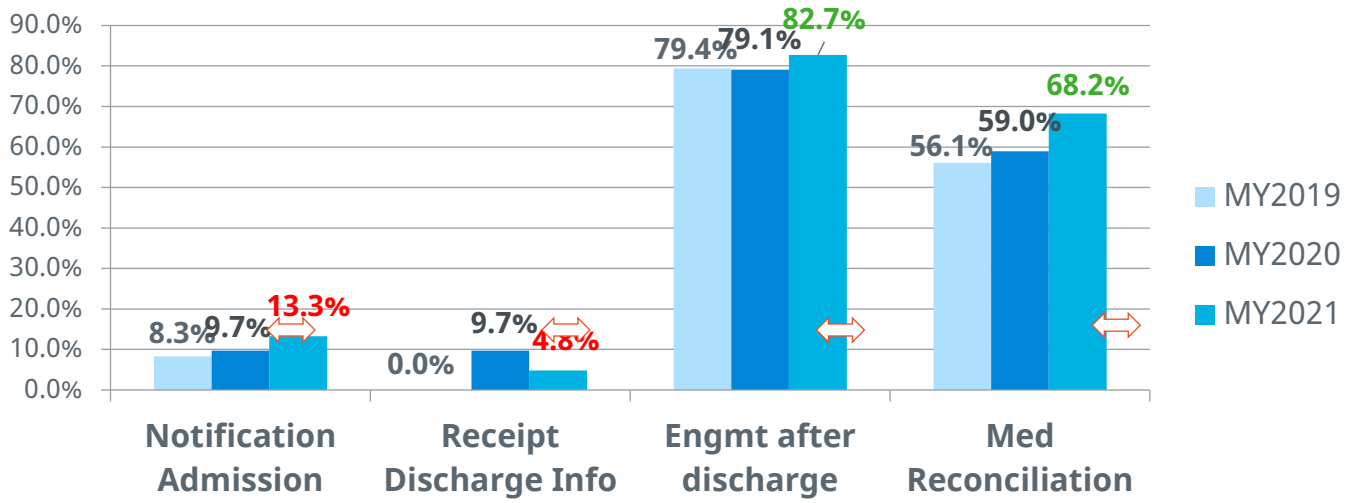
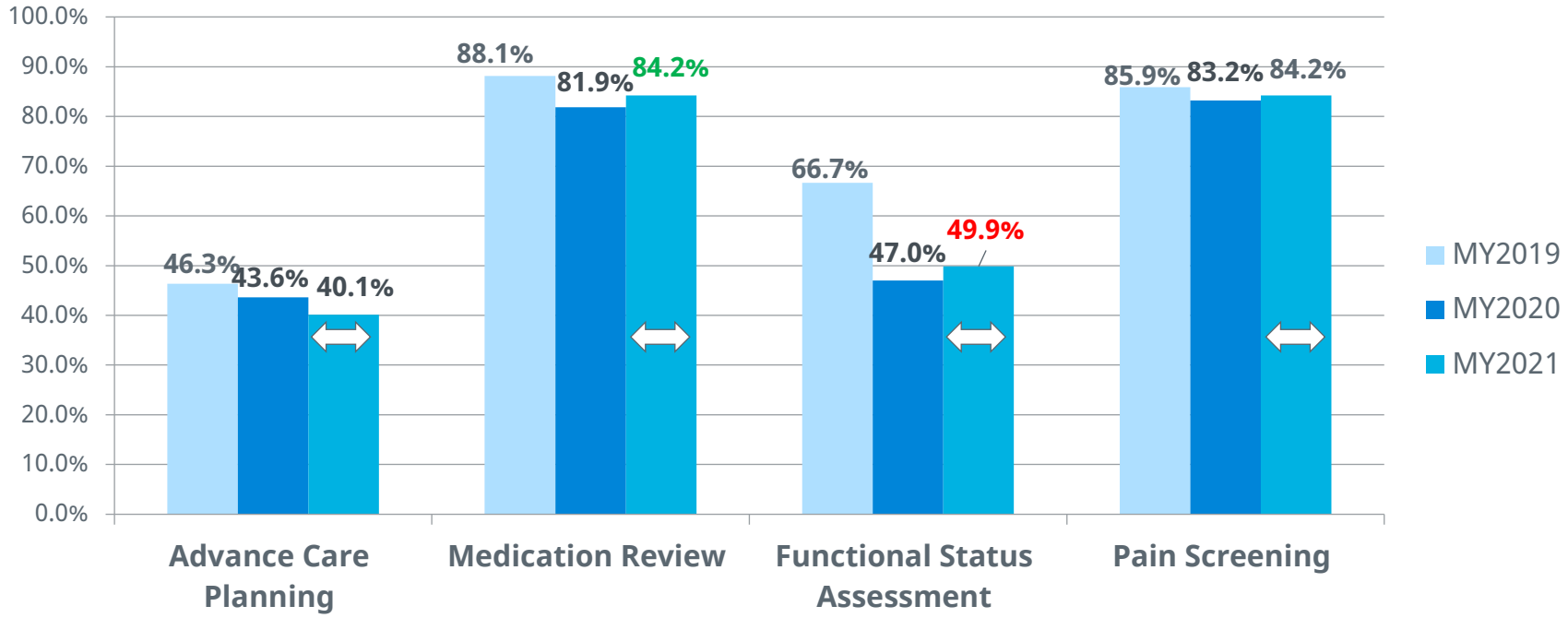
HEDIS MY2021 Results: OneCare Transitions of Care



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements**
Transitions of Care (TRC)					
Notification of Inpatient Admission	7.06%	21.9%	59.61%	12.38%	Star next year
Receipt of Discharge Information	4.38%	15.82%	45.01%	15.8%	Star next year
Engagement After Inpatient Discharge	78.35%	84.91%	90.27%	82%	Star next year
Medication Reconciliation Post-Discharge	62%	71%	84%	62%	Star

*Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year
↑ ↓ statistically higher or lower ↔ statistically no difference

HEDIS MY2021 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	71%	84%	95%	84%	Star
3. Functional Status Assessment	71%	85%	93%	71%	CMS
4. Pain Screening	76%	87%	96%	87%	Star

*Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year
↑ ↓ statistically higher or lower ↔ statistically no difference

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OneCare Connect (OCC) Results

Benchmarks — NCQA National Medicare HEDIS MY 2020 Percentile and CMS Medicare 2022 Part C & D Star Ratings Technical Notes 10/04/2021 Update

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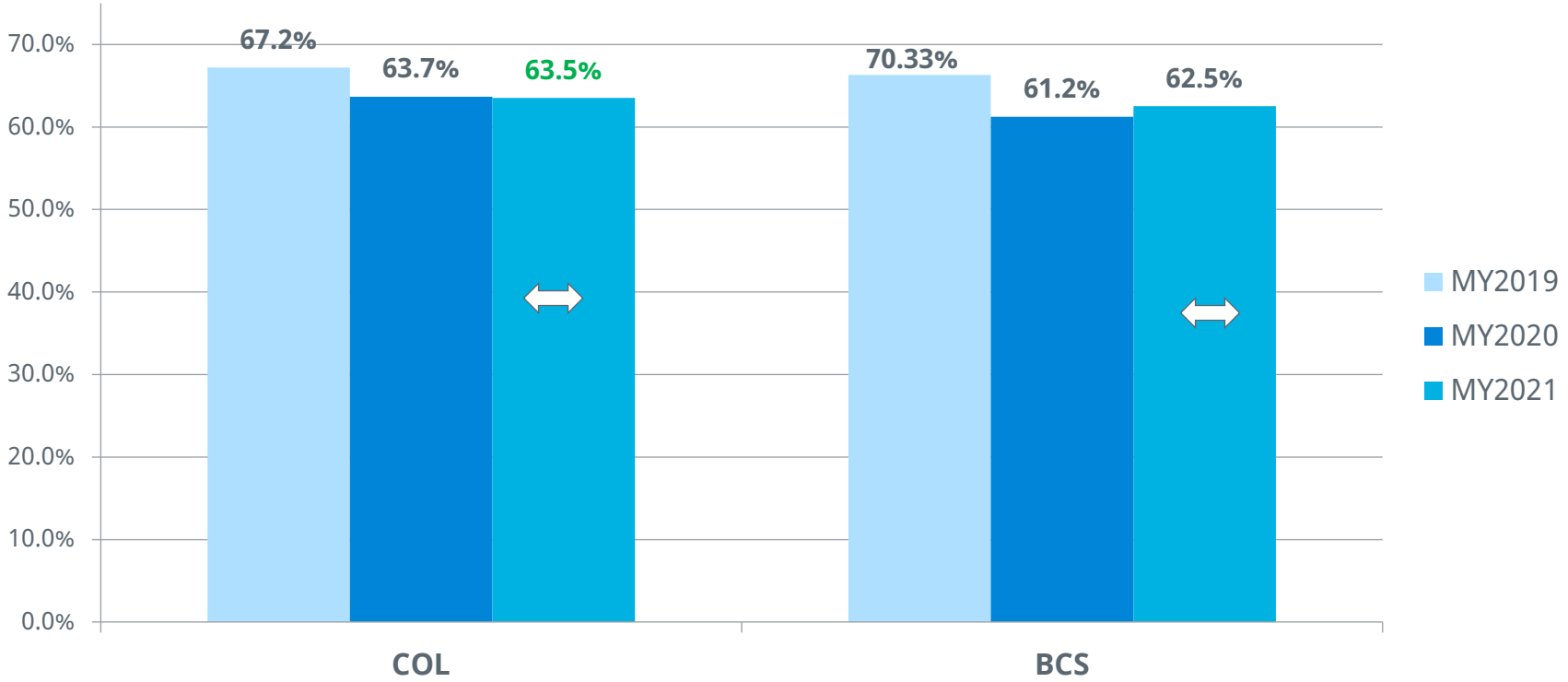
HEDIS MY2021 Results: OneCare Connect Prevention and Screening



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements**
Colorectal Cancer Screening (COL)	62%	71%	80%	62%	Star, P4V
Breast Cancer Screening (BCS)	61%	69%	76%	69%	Star, P4V

***Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year**

↑ ↓ statistically higher or lower ↔ statistically no difference

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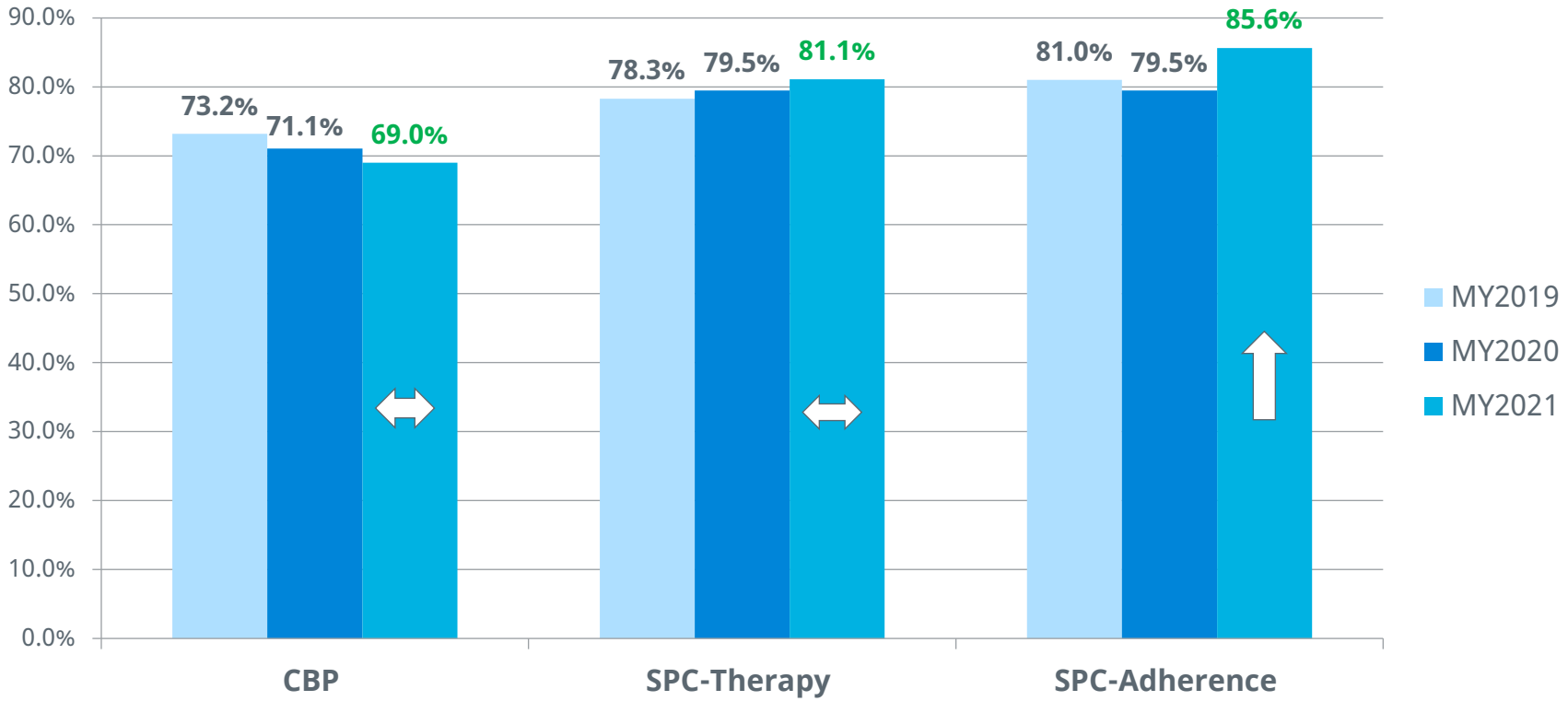
HEDIS MY2021 Results: OneCare Connect - Cardiovascular



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Controlling High-Blood Pressure (CBP)	58.88%	68.13%	77.37%	74.21%	Withhold
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Therapy	81%	84%	89%	**81.00%**	Star
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Adherence	83.23%	87.35%	90.94%	**82.27%**	CMS

***Red = less than 3-Star or 50th percentile, Green= met the goal** **Star cut points are previous year**

↑ ↓ statistically higher or lower ↔ statistically no difference

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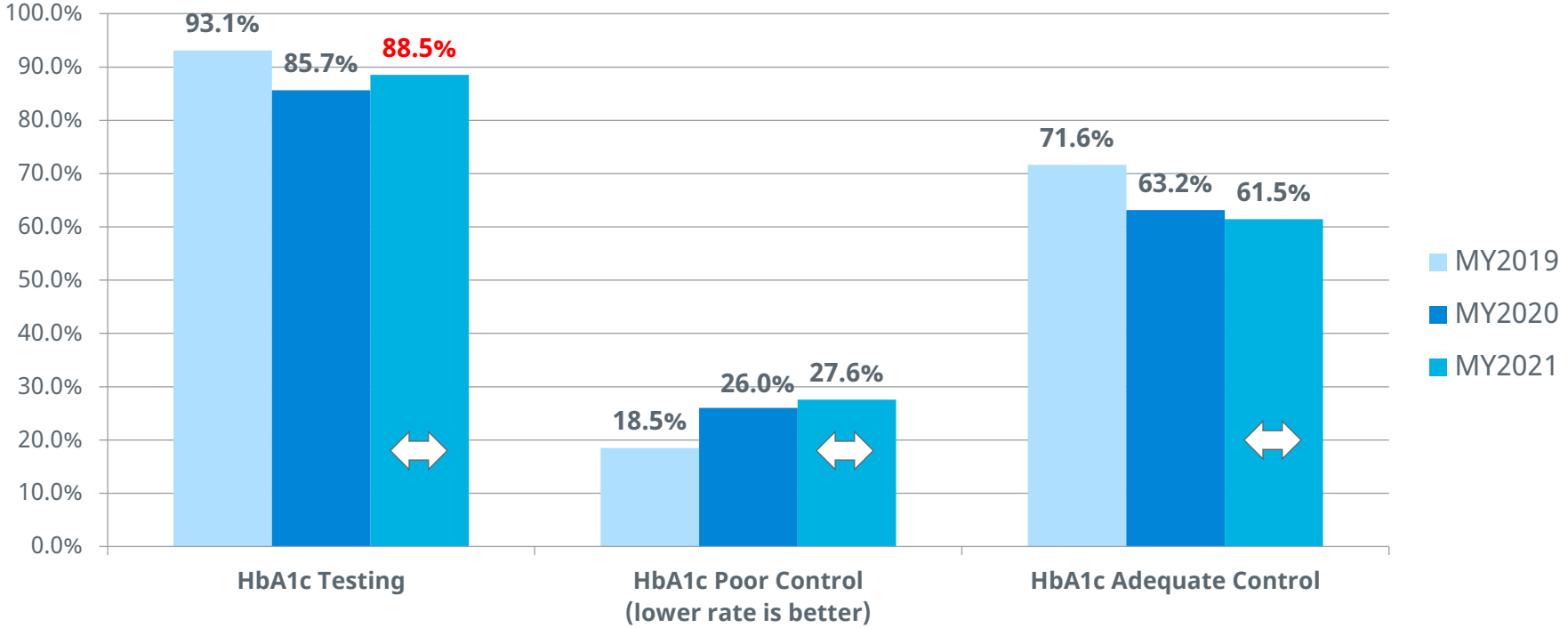
HEDIS MY2021 Results: OneCare Connect - Comprehensive Diabetes Care – HbA1c



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - HbA1c Testing	90.65%	93.92%	96.11%	89.18%	CMS
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%) **	40%	28%	19%	19%	Star, P4V
Comprehensive Diabetes Care (CDC) - HbA1c Adequate Control (<8.0%)	59.38%	69.80%	75.88%	65.69%	CMS

***Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year**

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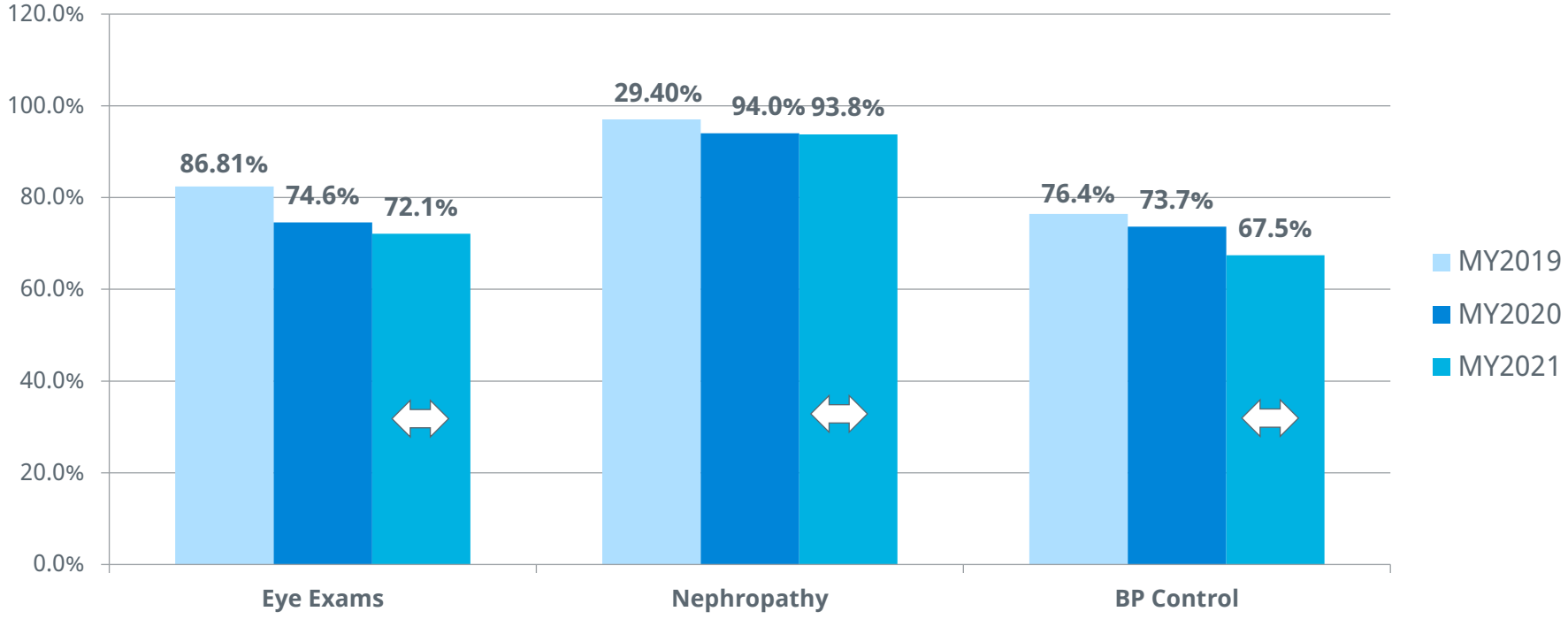
HEDIS MY2021 Results: OneCare Connect - Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - Eye Exams	62%	71%	79%	79%	Star
Comprehensive Diabetes Care (CDC) - Nephropathy Monitoring	88%	94%	97%	97%	Star
Comprehensive Diabetes Care (CDC) - BP Control (<140/90)	61.68%	69.53%	77.86%	74.94%	CMS

***Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year**

↑ ↓ statistically higher or lower ↔ statistically no difference

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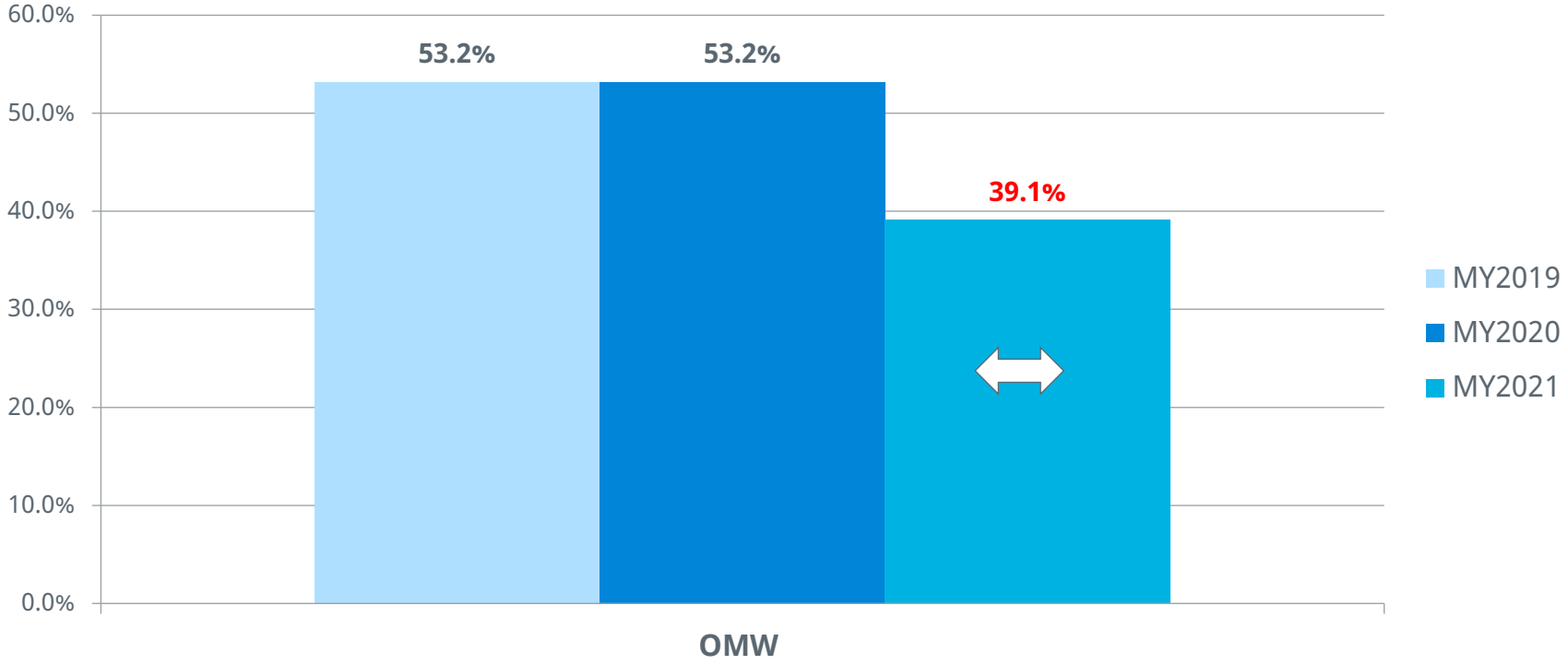
HEDIS MY2021 Results: OneCare Connect -Musculoskeletal Conditions



HEDIS Measure	3-Star	4-Star	5-Star	Goal	Reporting Requirements**
Osteoporosis Management in Women Who Had a Fracture (OMW)	40%	50%	68%	50%	Star

***Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year**
↑ ↓ statistically higher or lower ↔ statistically no difference

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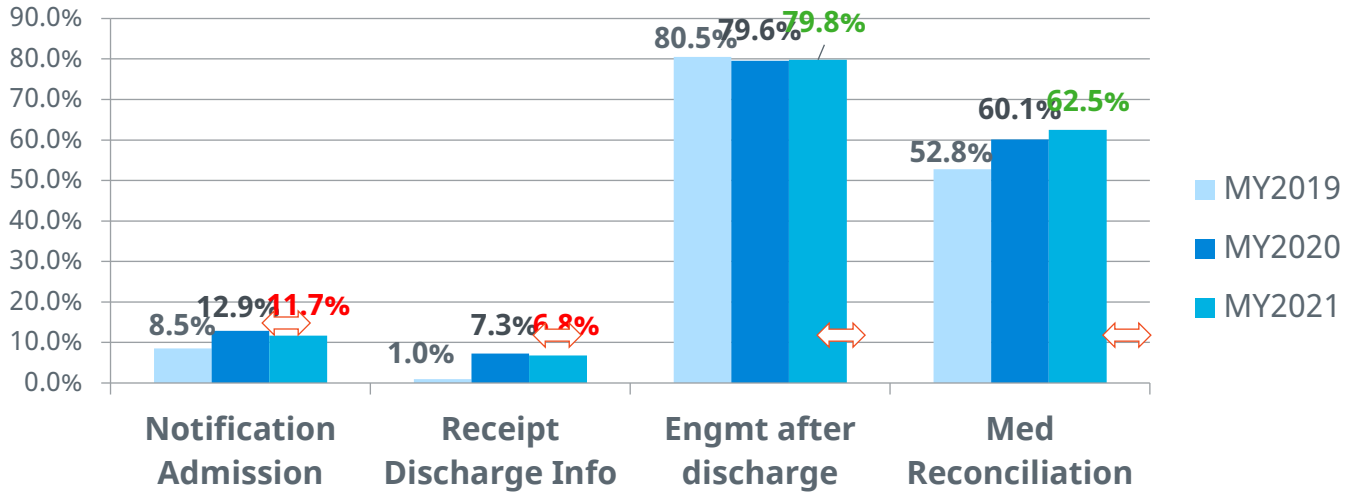
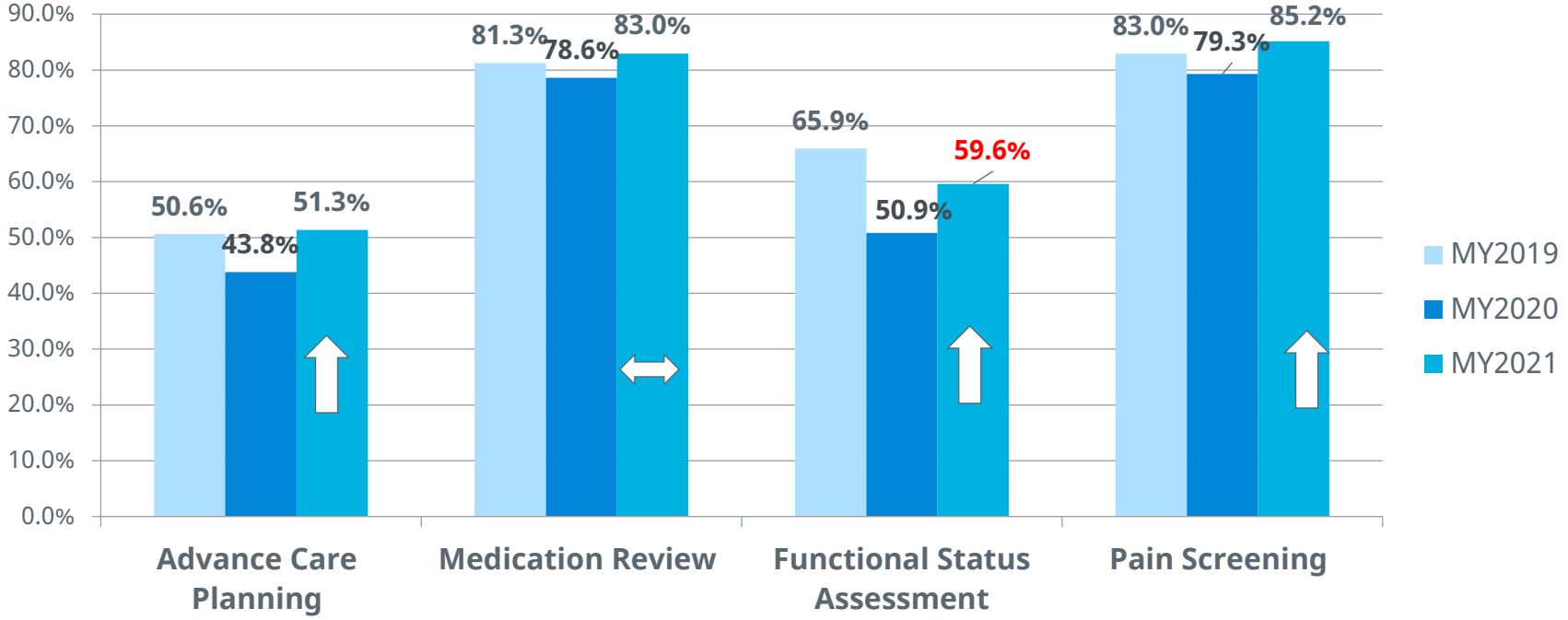
HEDIS MY2021 Results: OneCare Connect Transitions of Care



HEDIS Measure	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Reporting Requirements**
Transitions of Care (TRC)					
Notification of Inpatient Admission	7.06%	21.9%	59.61%	21.9%	Star next year
Receipt of Discharge Information	4.38%	15.82%	45.01%	8.03%	Star next year
Engagement After Inpatient Discharge	78.35%	84.91%	90.27%	81.98%	Star next year
Medication Reconciliation Post-Discharge	62%	71%	84%	62%	Star

*Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year
↑ ↓ statistically higher or lower ↔ statistically no difference

HEDIS MY2021 Results: OneCare Connect - 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	71%	84%	95%	84%	Star
Care for Older Adults - Functional Status Assessment	71%	85%	93%	71%	CMS
Care for Older Adults - Pain Screening	76%	87%	96%	87%	Star

*Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year
↑ ↓ statistically higher or lower ↔ statistically no difference

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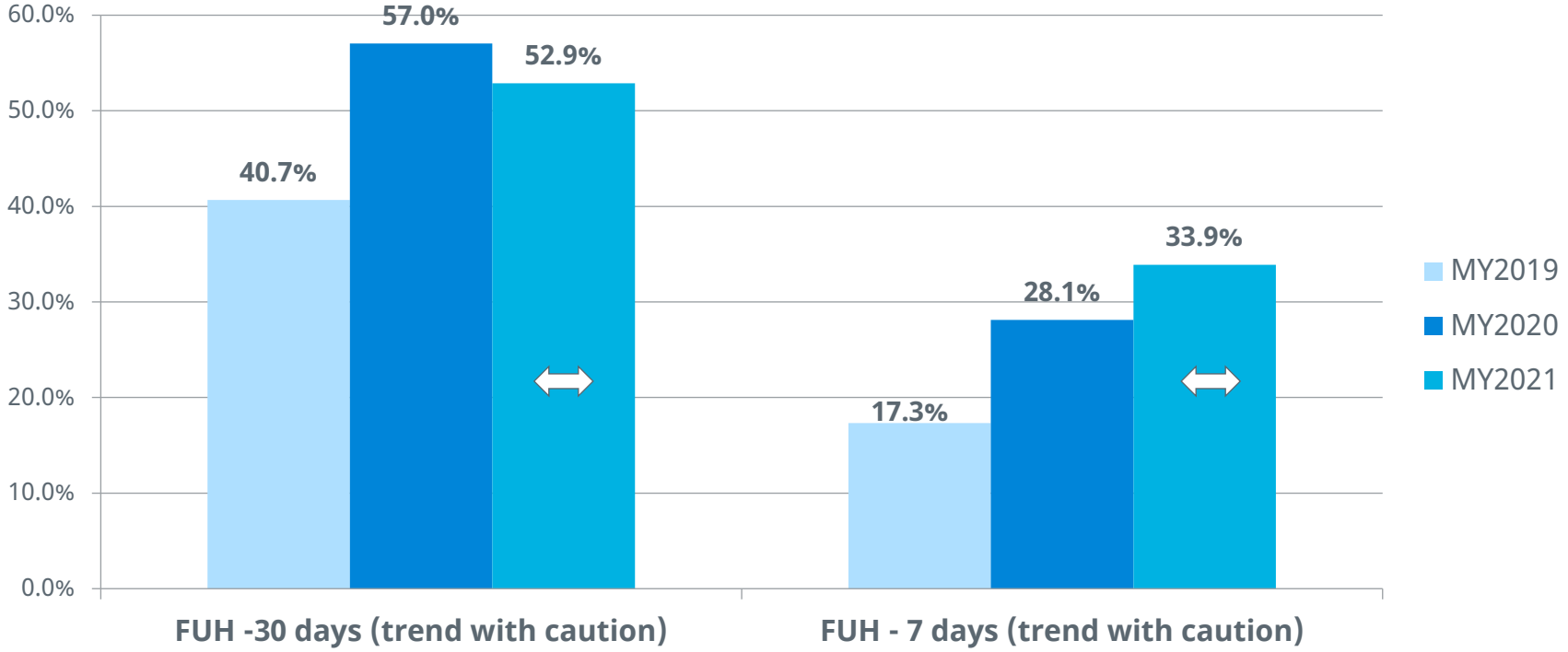
HEDIS MY2021 Results: OneCare Connect - Behavioral Health



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	41.22%	54.93%	73.03%	56%	Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++	22.22%	34.67%	50.74%	34.67%	CMS

*Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year

↑ ↓ statistically higher or lower ↔ statistically no difference

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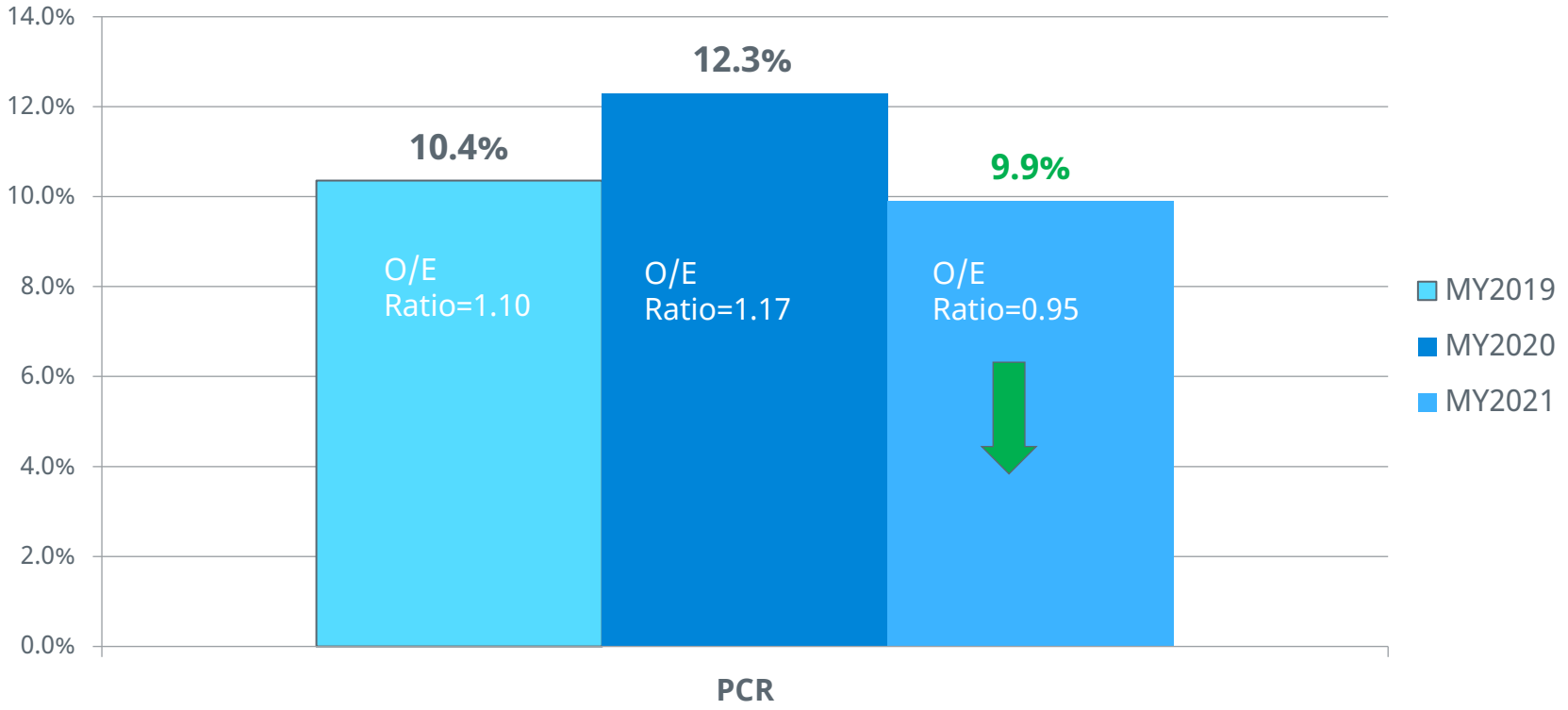
HEDIS 2021 Results: OneCare Connect - Plan All-Cause readmissions - 65+



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Plan All-Cause readmissions - 65+ (PCR) O/E Ratio	1.174	0.9912	0.8365	1.0	P4V, Withhold

***Red = less than 3-Star or 33rd percentile, Green= met the goal **Star cut points are previous year**
↑ ↓ statistically higher or lower ↔ statistically no difference

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Quality Initiatives Update

Quality Assurance Committee

September 14, 2022

Helen Lee Syn, Manager, Population Health Management (Quality Initiatives)

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Overview

- Quality Initiatives General Approach
- Current Quality Initiatives and Interventions
- 2023 Quality Initiatives Planning Process
- 2023 Interventions and Approach

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General Approach

- Member Awareness and Engagement
  - Media Outreach: Public Broadcasting System (PBS) ads, TV spots, digital and print ads, social media
    - Geotargeted and paid ads
  - Member Engagement: Texting, Interactive Voice Recognition (IVR) robocalls, live calls, targeted mailings, health coaching
- Access in the Community
  - Targeted events in the community
- Provider and Health Network Engagement
  - High-volume provider improvement projects, data sharing
  - Communication and joint collaborative interventions with health network

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Adult Preventive Interventions

- Breast Cancer (BCS)
  - Member engagement: Texting, IVR and targeted mailings
  - Access in community: Mobile mammography
  - Member Health Rewards
- Cervical Cancer (CCS)
  - Member engagement: Texting, IVR and targeted mailings
  - Member Health Rewards
- Colorectal Cancer (COL)
  - Member engagement: Texting, IVR and targeted mailings
  - Member Health Rewards
- High Blood Pressure (CBP)
  - Member engagement: Postcard mailings

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Adult Preventive Interventions (cont.)

- Flu (AIS)
  - Member engagement: Postcard mailing, text campaigns for flu and National Immunization Awareness Month
- Diabetes (CDC)
  - Member engagement: Health coach telephonic outreach
  - Member Health Rewards for A1C and eye exams
  - Provider engagement: Sharing VSP eye exam reports with health networks
- Statin (SPD)
  - Member engagement: Quarterly mailings to noncompliant members in statin therapy and statin adherence measures

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Child and Adolescent Interventions

- Child and Adolescent Immunization (CIS-10, IMA-2)
  - Member engagement: Telephonic and in-person surveys for barrier analysis, mailings, and texting
  - Access in community: IMA-2 Back-to-School Vaccination Event and COVID-19 clinics
  - Provider engagement: Detailed gaps report shared with offices
- Well Child and Well Care Visits (W30, WCV)
  - Member engagement: Well baby follow-up calls at three (3) months, six (6) months and 11 months
  - Provider engagement: Detailed gaps report shared with offices

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Child and Adolescent Interventions (cont.)

- Lead Screening in Children (LSC)
  - Member engagement: Member telephonic and in-person surveys for barrier analysis
  - Provider engagement: Gaps reports to health network and providers
  - Provider continuing education and continuing medical education
    - Led by Childhood Lead Poisoning Prevention Branch of California Department of Public Health
- Prenatal and Postpartum Care (PPC)
  - Member engagement: Bright Steps program
  - Member Health Rewards

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2023 Quality Initiatives Planning Process

- Identify 2023 Priority Measures
  - Annual evaluation process
  - Data Analysis
- Research and Discovery
  - Stakeholder feedback
- Implement Interventions

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2023 Interventions and Approach

- Member Engagement
  - Provision of culturally sensitive services for community-based education, patient advocacy
    - Community Health Workers
    - Doulas
  - Expanding Member Portal
    - Gaps in care reminders
    - Digital Member Health Rewards
    - New health rewards
  - Expanding Access to Services
    - Remove structural barriers
      - Mobile Mammography
      - Community Based Services
      - Expanded hours or additional staff
      - Interpretation Services
      - Patient Navigators
      - Telehealth promotion

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2023 Interventions and Approach cont.

- Provider Engagement
  - Provider reminder and recall system enhancement
  - Consider new provider incentives
- Standing orders for screening, labs, exams
- Improve data exchange
  - Data sharing
  - Expand use of Provider Portal
    - Gaps in care reports
  - Electronic Medical Record data bridging

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Board of Directors' Quality Assurance Committee Meeting
September 14, 2022

PACE Member Advisory Committee Update

Committee Overview
The PACE Member Advisory Committee (PMAC) meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima Health PACE leadership on the PACE care delivery system. The committee is primarily comprised of PACE participants.

June 22, 2022: PMAC Meeting Summary

Updates from the Director
Director Monica Macias thanked PMAC members for joining the meeting in person for the second time in two years since the pandemic. Members were updated on the status of the program. PACE is slowly allowing participants to return to the day center. Currently, we have two shifts (am/pm), allowing up to 30 participants per shift totaling 60 per day. All participants are assigned to pods, with social distancing in mind, and must wear mask. The clinic and skilled rehabilitation appointments continue to operate as usual. In addition, we are slowly increasing number of participants on the vehicles, currently allowing 4-5 participants per vehicle per trip. Our staff has returned to the PACE center and Director noted that we are still recruiting for open positions.

COVID-19 Updates
Jennifer Robinson, Quality Improvement Manager, provided updates related to COVID-19 numbers and status. Jennifer provided an update on COVID-19, sharing that currently OC went from the low to medium tier, because of the current high-rate cases, wearing mask is highly recommended. PACE is continuing our vaccination efforts and providing education to participants. Current vaccination rates, 97% have received their initial (2 doses) and 88% have received their 3rd dose (first booster). Jennifer also provided education around the 4th dose (2nd booster).

Jennifer educated our participants with the Alternative Format Selection notification that was mailed out to everyone. The notice is informing the participants that they can request through their Social Worker any written materials to be provided in different format like large print, braille, or data CD. Participants acknowledged receiving and understanding.

PMAC Member Forum
- A participant shared that he is seeing improvement in our transportation services and want to make sure this continues.
- Participants asked if PACE would increase day center attendance even more. It was noted that the plans are to continue to increase with caution and safety in mind.
- A participant commented on the new paint indicating that we are doing a great job and likes the new colors.
- Participants were reminded of the suggestion box in the center if they have any concerns or compliments, they would like to share with the staff.

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CalOptima Health Board of Directors'
Quality Assurance Committee Meeting
September 14, 2022

Quality Improvement Committee Second Quarter 2022 Report

Summary

- Quality Improvement Committee (QIC) met April 14, 2022, May 10, 2022, and June 14, 2022
- The following departments and subcommittees reported to QIC in Quarter 2 (Q2):
    - Quality Improvement (QI) Department
    - Quality Analytics (QA) Department
    - Behavioral Health Integration (BHI) Department
    - Long Term Services and Supports (LTSS)
    - Utilization Management (UM) Department
    - Utilization Management Committee (UMC)
    - Whole-Child Model Clinical Advisory Committee (WCM CAC)
    - Credentialing and Peer Review Committee (CPRC)
    - Member Experience Committee (MEMX)
    - Grievance & Appeals Resolution Services Committee (GARS)
- Approved and filed the following:
    - QI Policies
        - Policy GG.1603 - Medical Records Maintenance
        - Policy GG.1607 - Monitoring Adverse Actions
        - Policy GG.1650 - Credentialing and Recredentialing of Practitioners
        - Policy GG.1651 - Assessment and Re-Assessment of Organizational Providers
        - Policy GG.1655 - Reporting Provider Preventable Conditions (PPC)
        - Policy MA.1201p - Medicare Non-Monetary Member Rewards & Incentives
    - Policy MA2101p: Medicare Non-Monetary Member Rewards & Incentives Policy
    - List of Board-Certified Consultants 2022
    - 2021 UM Program Evaluation
    - 2022 UM Program Description
- Accepted and filed minutes and QI Work Plan from the following committees and subcommittees:
    - WCM CAC meeting minutes: November 16, 2021
    - MEMX meeting minutes: February 9, 2022
    - 2021 Quality Improvement (QI) Work Plan Q1
    - UMC Meeting Minutes_11 18 21_Final
    - WCM CAC Meeting Minutes 11.16.21
- Change in Quality Improvement Committee Members

- New CalOptima Health Deputy Chief Medical Officer, Dr. Zeinab Dabbah
- New CalOptima Health Medical Director(s) Dr. Rich Lopez, Jr., and Dr. Shilpa Jindani
- Dr. Patricia DeMarco Psychiatrist and Medical Director, Mental Health & Recovery Services replaced Dr. Angela Yu as County Behavioral Health County Representative
- Dr. Lance Brunner is a new attendee to QIC meetings joining on behalf of Dr. Todd Newton from Kaiser Permanente

QIC Quarter 2 2022 Highlights

- **Chief Medical Officer (CMO) Updates**
  - CMO provided updates, guidance and feedback related to committee activities, which included:
    - Coronavirus (COVID-19) safety, boosters, and treatment
    - National Committee of Quality Assurance (NCQA) plan to stop accepting paper charts for verification.
      - Centers for Medicare & Medicaid Service (CMS) requesting all medical record information for Healthcare Effectiveness Data and Information Set (HEDIS) calculations be sourced from electronic data sources.

- **Quality Program Highlights**
  - Quality Analytics staff submitted HEDIS Measurement Year (MY) 2021 results to NCQA on June 13, 2022
    - Medicare patient level detail files passed audit review. All measures are fully reportable for all lines of business
    - All Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) selected measures achieved Minimum Performance Level (MPL)
      - Well-Child Visits measure (W30) did not meet MPL (new MCAS measure)
  - Pay-for-Value (P4V) programs
    - OneCare Connect (OCC) P4V program will be sunset at the end of 2022
    - New P4V programs for both Medi-Cal and OneCare (OC) are in development for MY2023
      - Present to Q3 QIC for input
      - Followed by presentation at QAC for approval

- **Health Equity** update by Katie Balderas, Director, Population Health Management (PHM)
  - Health Equity & Social Determinants of Health (SDoH) Workgroup formed in January 2022
    - Comprised of CalOptima Health staff from a variety of roles and departments
    - Workgroup activities:
      - Co-created a working definition of health equity
      - Reviewed several existing health equity frameworks
      - Drafted a framework for CalOptima Health's health equity efforts

- **Homeless Health Initiatives (HHI)** update by Katie Balderas, Director, PHM
    - Goal: Enhance and strengthen the delivery system to better meet the needs of individuals experiencing homelessness
    - In 2019, CalOptima Health made a $100 million commitment to fund initiatives under HHI
        - Homeless Clinical Access Program (HCAP)
            - Monthly incentive paid to clinics, with mobile units, to provide primary and preventive healthcare at Homeless shelters and hotspots
                - Eight different clinics at 32 different locations
                - Services rendered via on-call and telehealth added in response to COVID-19
            - HCAP has served over 6,000 individuals experiencing homelessness
        - Clinical Field Team (CFT)
            - Four clinics provided services to individuals experiencing homelessness wherever it is needed such as shelters, streets, parks, encampments, and other locations
            - April 2019 - December 2021 CFT dispatched calls:
                - 73% members
                - 13% nonmembers
                - 14% prior members (previously eligible with CalOptima Health)
        - Homeless Response Team
            - Case management and personal care coordination services provided to members experiencing homelessness with access care
            - Between 2019 and 2021, CalOptima Health staff completed 631 outreaches
    - HHI has resulted in decrease utilization of the emergency department (ED) across all initiatives
    - A Request for Proposal (RFP) to help transition pilots into a comprehensive street medicine program is set to launch at the end of 2022 or early 2023

- **Department of Health Care System (DHCS) Comprehensive Quality Strategy (CQS)** overview provided by Marsha Choo, Director, Quality Improvement.
    - Ten-year vision to improve quality of life and eliminate health disparities
    - Integrates a whole-system, person-centered and population health approach to care
    - Focus on three target clinical areas:
        1. Children's preventive care
        2. Behavioral health integration
        3. Maternal care

- **Post-Acute Infection Prevention Quality Incentive (PIPQI)** update provided by Michelle Findlater, Manager, Long Term Support Services (LTSS)
  - Provided incentives to healthcare sites to implement bathing and Iodophor protocols.
  - Program funding ending in March 2022
  - Extension requested in April 2022 with the following program modifications:
    - $7,500 quarterly incentive removed
    - Reducing baths from every other day to two per week
    - Six least compliant facilities removed from the program
  - PIPQI team will continue to track and trend data
  - Compliance will be based on new program requirements for Q2 2022

- **Plan Performance Monitoring and Evaluation (PPME)/Quality Improvement Program Effectiveness (QIPE): Health Risk Assessment (HRA)** update was provided by Denise Hood, Manager, Case Management.
  - PPME and QIPE performance areas projected to meet goal for Q1 2022
  - Oversight of Model of Care included January and February performance (March data pending)
  - Continue to monitor LTSS HRA for timeliness on outreach for completion and regulatory reporting quarterly

- **California Advancing and Innovating Medi-Cal (CalAIM)** update provided by Gail McMillen, Manager, Case Management.
  - QI work plan goals for CalAIM are improving health and access to care for enrolled members
  - Four targeted activities to achieve goals:
    1. Transition of Health Homes Program (automatically authorized for Enhanced Care Management [ECM]) services
    2. Transition of Whole Person Care (automatically authorized for ECM) services
    3. DHCS Reporting
       - Data in process - being pulled from authorization, claims and weekly log activity submitted by the networks
    4. Establish oversight - first implementation audit completed
  - Staff is conducting outreach to the populations of focus including:
    - Members and families experiencing homelessness
    - Members who are considered a high utilizer
    - Members with severe mental illness or substance use disorder

- **Quality Improvement Department** update provided by Katy Noyes, Manager, Quality Improvement
  - Facility Site Review (FSR) Corrective Action Plan (CAP)
    - Increase in issued CAPs were due to provider office staff shortages
- **Behavioral Health Integration (BHI)** update provided by Natalie Zavala, Director, Behavioral Health Integration

- BH Clinical Quality Measures
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD):
    - Provide a list of members in need of diabetes screening to the providers
  - Follow-Up After Emergency Department Visit for Mental Illness (FUM) Emergency department (ED) visits for members 6 years of age and older with a diagnosis of mental illness and who received a follow-up visit for mental illness
    - Staff developing a report on member ED visits and identify trends
    - Health Network Quality (HNQ) meeting to report, discuss and address barriers

- **Utilization Management Committee (UMC)** update provided by Mike Shook, Director, Utilization Management
  - UMC reviewed and approved the 2021 UM Program Evaluation and 2022 UM Program Description as presented
  - November 2021 UMC report presented
    - Q4 2021 annual trends
      - Operational Performance
        - Medical Auth (Medi-Cal/OC/OCC):
          - Continue to have some HN and CCN authorizations not meeting ≥ 98% goal
            - Only trend noted was CCN due to backlog-resolved 1/27/22
        - Unused Authorization (Medi-Cal):
          - Year over year improvement noted in rates
    - Utilization Outcomes
      - Medi-Cal and OCC Measures: Beddays (PTMPY), Readmissions, and ED Visits are trending down
    - Operational Performance WCM
      - NICU/PICU/Durable Medical Equipment (DME)Inpatient/SCC Denials:
        - Volume low
        - Generally found to be appropriate and related to medical necessity
      - Beddays/K: Year-over-year decrease in beddays
      - Readmissions: Relatively flat for 2021
      - ED visits/K: Year-over-year decrease in ED Visits

- **BHI UM Q4 2021** update was presented by Dr. Donald Sharps, Behavioral Health Medical Director
  - Service Type
    - Trends related to Medi-Cal for outpatient psychiatric and psychotherapy services have remained steady. Encounters are mostly adults.
    - Trends related to OC/OCC, the number of encounters, and the trend of utilizing members have remained stable of the last two years.
    - Encounters per member month and the trend broken down by psychiatric and psychotherapy visits separately have also remained stable for the last two years.
  - Average Length of Stay (ALOS) and % Re-admission:
    - Goals were met for ALOS of 11 days.
    - Re-admission goal of 22% was not met
      - OC/OCC members is relatively small so the percentage can change with the readmission of just one member.
  - Behavioral Health Treatment (BHT) Monitoring - Overall Performance:
    - Measuring the average utilization vs. authorization over five quarters using the BHT services codes for monitoring
    - Utilization vs authorization is 35%. Threshold of 45% not met
      - Staff is educating provider to meet threshold
- Benefit Management Subcommittee (BMSC) Meetings held on 10/27/21, 11/24/21 & 12/22/21. Total codes reviewed Q4'21 (52); Determined Prior Authorization (PA) Required (19); Determined NO PA Required (33)
- List of Board Consultants – Approved list of board-certified consultant groups that provide service and covers specialties that CalOptima Health does not have expertise
- 2021 UM Program Evaluation and 2022 UM Program Description were presented and approved by QIC

- **Member Experience** presented by Marsha Choo, Director, Quality
  - Updates on subcommittee that met on February 9, 2022, and reviewed, updated, and approved by Member Experience Committee Charter
  - Access and Availability
    - Staff fielded a Timely Access Survey to CalOptima Health providers to collect information on appointment availability and office wait times
    - CalOptima Health is collecting and finalizing the 2021 survey cycle and may be issuing Corrective Action Plan (CAP)s in the next couple of months to Primary Care Physician (PCP)'s and specialists.
  - Customer Service (CS) participation:
    - Increase in the number of members who decline to file grievances

- Utilization Management update:
  - Backlog of prior authorizations have been remediated and are meeting turnaround time standards.
- STAR Scores workgroup:
  - Member Experience Committee has been reviewing the overall member experience in Star scores and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores with focus on Dual-Eligible Special Needs Plan (D-SNP) or OneCare plan.
    - CAHPS scores are now weighted four times more than any other clinical measures.
  - Workgroup reviewed CalOptima Health's OneCare CAHPS scores to identify:
    - Opportunities to address member pain points and improve member experience for OneCare members.
    - Current initiatives that CalOptima Health is already doing around OneCare members for member experience

- Network adequacy results and data for Q1, 2022:
  - CalOptima Health met all the areas for plan level, with the exception occupational therapy facilities for OneCare.
    - HNs are meeting most standards for PCPs, but not all specialists for provider to member ratio and time/distance standards.
    - Medi-Cal health networks focus on sub-delegate network adequacy.
    - Mandatory Provider Types not met for Certified Nurse Midwives (CNM) and Licensed Midwives, since DHCS is requiring a CNM licensure

- **Whole Child Model** updates presented by Dr. Thanh-Tam Nguyen, Medical Director, Medical Management
  - Summary of WCM CAC meeting held February 15, 2022
    - Susan Gage, Children's Hospital Orange County Pulmonary specialist was added to the Committee
    - Annual Committee Conflict of Interest and Attestations were completed
    - Case Management presented a CalAIM update on the transition of approximately 2,000 members from WPC Pilot and the Health Homes Program to the ECM program and Community Supports Services
    - Pharmacy Director, Dr. Gericke provided Medi-Cal Rx update - DHCS decision to remove prior authorization requirement has reduced backlog
    - UM, GARS, and CS gave a report on WCM measures
    - Dr. Nguyen shared DHCS CCS Number Letter Updates proving a copy of CCS-NL-03-0421_WCM_CM-Revised and MTP-COVID-Step-3b-02-04-22-SA

- Credentialing Peer Review Committee (CPRC) updates presented by Laura Guest, Manager, Quality Improvement
  - Credentialing

        - In March, it was identified that 57 CalOptima Health contracted provider groups were not credentialed, of which eight were Primary Care Physicians.
            - Most of the individual practitioners were credentialed and the group (NPI 2) was not credentialed.
            - The action was reported to DHCS.
        - Two potential 805 reporting in Q2 2022:
            - One may affect several health networks.
            - Fair Hearings commencing for both providers to look at the information from both the providers and from CalOptima Health perspective
    - Facility Site Review Activity
        - QI staff is creating and distributing educational materials and tools to provider offices the launch of the new DHCS requirements or standards.
        - Tools will have a major impact to the primary care physicians.
        - The concern is that the MRR preventive section for Pediatric and Adult has doubled in scope.
        - The audit will now take two days instead of one by CalOptima Health RN staff
    - Potential Quality Issues (PQI) – There was an increase of cases leveled as Quality of Care (QOC) sharp decline of PQIs, because the denominator has changed likely due to the change in workflow for Quality-of-Care grievances
        - Appeal - There was an appeal of a denial for recredentialing of an Applied Behavioral Analyst (ABA) Group that occurred a few months ago.
    - CalOptima Health's Credentialing and Peer Review Committee reviewed and upheld its decision to deny the recredentialing of the ABA group

- **Grievance and Appeals Resolution Services (GARS)** updates presented by Tyronda Moses, Director, Grievance & Appeals
    - Q1 2022 grievance and appeals trends
        - The total grievances received are trending down in comparison to Q4, 2021.
        - There were multiple providers with multiple complaints against them within the quarter.
    - Providers have been identified and staff is reaching out to both the provider and network
        - Staff is educating members on emergency care billing
        - Members failed to provide a copy of their Member ID card at emergency care visits when they received the bill.
        - CCN and COD, combined, accounted for 44% of the overall grievances for Q1
        - Member grievances and Appeals had decreased for all LOB
    - Medi-Cal State Hearings: Upheld 9 times, dismissed one of the cases
    - Provider Appeals Summary: Top Provider Appeals was for three facilities

Attachments

2022 QI Work Plan – First Quarter

2022 Quality Improvement Work Plan
1Q Update

2022 QI Work Plan Element Description	Goals	Planned Activities	Staff Responsible	Report to Committee	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT							
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Marsha Choo	QIC	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Marsha Choo	QIC	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Mike Shook	QIC	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Mike Shook	QIC	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Marie Jeannis/Kelly Giardina	QIC	Strategy is current. We will need to update to align with 2022 HP NCQA requirements and DHCS.	Meeting will be scheduled in 2Q2022 to update.	
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.	Marsha Choo/Laura Guest	QIC	**I. FSR/PARS/NF/CBAS** Subject: Anticipated launch of new DHCS FSR/MRR tools and standards July 1, 2022. Point of Information: Anticipate CBAS in-person services to begin July 1, 2022. **II. Credentialing/Recredentialing** Subject: Identified in March 2022: Organizational Providers - OneCare Project. For CCN and BH, there were 57 group practices that were identified as not credentialed, although the individual practitioners were credentialed. **III. PQI** Subject: Since cases are being reviewed while a grievance, the % of cases leveled as QOC has increased from 4-7% prior to 2021 to now at 21%. Subject: Fair Hearing for Notice of Termination - Potential 805 Reporting 1. PQI and FWA investigations - PM physician was billing for PT and psychotherapy services under his NPI 1, billing for 99215 for services rendered by a LVN, and was unable to produce medical records for several members due to destroying the medical records while converting to an EHR. 2. PQI Investigation - PCP attending at hospital for member who was admitted for hand cellulitis, had precipitous drop in Hgb, never referred to GI or hematology for etiology, and unexpectedly expired.	**I. FSR/PARS/NF/CBAS** Actions: A. Working with PR, HNR and communications to send educational materials and tools for provider office B. Training providers and their staff, and the FSR Nurses C. Implementing changes to on-line tool data collection D. MRR tool preventive section has doubled for both peds and adult Concern: May lead to an increase in: 1)failed FSR and/or MRR audits, and 2)FSR/MRR CAPs issued **II. Credentialing/Recredentialing** Actions: A. As of May 31, 37 were processed for credentialing, including 5 PCPs. B. 14 OPs were identified for termination for various reasons. **Concerns:** A. Several OPs are missing required documentation for credentialing, which may lead to termination; B. May result in a drop in network adequacy for some specialties and/or PCP by geographic region. **III. PQI** Action: Continue with QOC grievance review by RN and MD Concern: Volume of PQIs are climbing again from 42 in December to 100 in May Action:Fair Hearings Commencing in Q2 **Concerns**: Results of Fair Hearing will be reported to QIC in Q3 and terminations may affect several networks. 1. PM- Provider termination will only affect the CCN network. 2. PCP - HPN/Regal, CCN, Optum-Arta, Optum-Talbert, Prospect and UCMG will all be affected by potential termination. HNs will be notified if Fair Hearing results in termination.	

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Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Tyronda Moses	QIC	On March 8th 2022, GARS Committee presented to QIC 4Q Member and Provider Complaint results. **- Medi-Cal Complaints:** 9% increase in total complaints; 7% decrease in member appeals; 5% increase in member grievances; 25% increase in provider appeals **- Medi-Cal Grievances by Category:** QOS continues to be the highest Grievance category. QOS increased by 11% from Q3 to Q4. CCN and Veyo continue to have the highest number of QOS grievances. **-- Other Increases:** Quality of Care increased by 32% (from 206 in Q3 to 272 in Q4). AltaMed, Monarch, CCN, COD had the most noticeable increase in QOC grievances. **-- Decreases:** Billing decreased by 2%; Access decreased by 17% (from 731 in Q3 to 609 in Q4); Appointment Availability (177 grievances); Telephone Accessibility (122 grievances) Specialty Care (101 grievances); Practitioner office site decreased 33% (from 9 in Q3 to 6 in Q4) **- Medi-Cal BH Grievances**: 28% decrease in BH grievances; Access decreased by 27%; QOS decreased by 32%; QOC decreased by 30%; Billing decreased by 6% **- OCC Complaints:** 10% decrease in total complaints; 32% decrease in appeals; 13% decrease in grievances; 22% increase in provider appeals **- OCC BH Grievances**: BH grievances increased by 4 in Q3 to 9 in Q4. **- OC Complaints:** 25% decrease in total complaints; Member appeals remained the same from Q3 to Q4; 12% decrease in member grievances; 59% decrease in provider appeals	Grievance trends are reviewed for repeated issues. High grievance count by providers are tracked and trended. Results are shared with a Provider Action workgroup for recommended action or escalation to the Member Experience Committee. Next GARS Committee is scheduled for QIC on June 14th.	
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Kelly Rex-Kimmet/Marsha Choo	QIC	In Q1, MemX Committee has reviewed/discussed the following: **2/9/22:** •Updates -Q4 workplan updates due 2/11 •Charter Review •DHCS Audit Findings •UM Dept Update •2022 Workplan Review •HN Improvement Plan	In Q2 MEMX Committee has one meeting scheduled, April 5.	
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	Utilization Management/QIC	UMC reported to QIC on 2/15/2022. Presented 2021 3rd Quarter and Annual Trends (11/18/2021), - 3Q 2021 Operational Performance (MC,OC,OCC) Medical Auth 3 HN below goal for Urgent TAT, 1 for routine TAT - 3Q 2021 Utilization Outcomes (MC, OCC) Medical Measures met Goals, OCC measure Beddays and Readmissions did not meet goals - 3Q 2021 Operational Performance WCM goals are to TBD. - Prior Authorization (PA) Backlog update (Person: Leadership accountability and oversight, UM role vacancies, Process: Workflows lacked efficiency and visibility Lack of prioritization and planning System/Technology Clinical platform upgrade and ongoing maintenance, Staff readiness for platform upgrade) - Over/Under Utilization Monitoring, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BH UM Update, BHI. - QIC accepted and filed meeting minutes from UMC Meeting (8/26/21).QIC Accepted and filed all documents.	UMC is scheduled to present Quarterly update to QIC on 4/12/2022. Along with DRAFTs of 2022 UM Program, 2021 UM Evaluation and List of Board Certified Consultants (AMR/MRIpA/Internal.)	

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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	QIC	WCM CAC met on February 15, 2022 and approved the November 16, 2021 meeting minutes. Committee annual Conflict of Interest and Attestation forms were completed by all attendees. An update on the CalAim program was presented by Case Management Director, Sloane Petrillo. An update on Magellan Rx backlog issues of prior authorizations was shared with the Committee. CalOptima with collaboration of CHOC and UCI held meetings with Magellan in response to the issue. Magellan has hired additional staff and many prior authorization requirements were removed and the backlog issue has been caught up. Committee has concerns of a back log issue recurring when the prior auths are lifted in May. Will present an update at the next WCM CAC. Standing agenda updates for WCM Measures, GARS, and WCM Customer Service Inquires were presented. DHCS notice updates of CCS Medical Therapy Program Step 3b Guidance Related to Return to In-Person Services and DCHS Numbered Letter 03-0421 related to CCS program were also shared.	Next meeting scheduled for May 17, 2022 with an update to the Magellan RX backlog issue to be reported along with the standing recurring agenda items.	
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Sandeep Mital	QIC	Preliminary analysis of MY2021 performance on the measures indicates that CalOptima has passed 7 of the 10 measures, which would make us eligible to receive 75% of the OneCare Connect Quality Withhold dollars back.	We will receive final confirmation of MY2021 performance from CMS in 2023 and then calculate and distribute health network withheld dollars.	
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, **OC P4V,** Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures. **[NEW] Development of the OC P4V program for MY2023**	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital	QIC	HEDIS MY2021 results achieved MPL for all DHCS selected measures except the newly added well child visits (W30) measure.	We are continuing to monitor performance in 2022 on a monthly basis. Next update to QIC will be in Sept .	
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs **MC PIPs:** 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Helen Syn	QIC	1) Successfully met all required criteria for Module 3. Began testing intervention. Mobile Mammography Event Q1: Completed 12 BCS for KCS CCN members. 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members. Module 1-3 Submitted and approved. Began testing intervention.	1) Continue testing intevention through the end of the PIP December 31, 2022. Scheduled KCS Mobile Mammogrophy Events for for 5/17, 8/15, and 10/24. 2) Continue testing intervention through the end of the PIP December 31, 2022. New target list for 2022 denominator provided to office (April).	

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Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs **MC QIP:** 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N. Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Natalie Zavala/**Helen Syn**	QIC	**MC QIP** 1) COVID QI Phase 2- a. SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS- Cycle 1: 3 provider offices conducted member outreach with combined CCS denominator of 4,235 and target outreach popuation of 2,172. The combined outreach rate at the end of cycle 1 was 53.22 % (1156/2172). Provider office staff received predetermined incentive based on the count of the target outreach list if 90% of members identified on target list were outreached. c. CIS Combo 10- Cycle 1 (10/14/21-12/31/21): Provide Office outreached and reconciled 100% of their target list of 663 members. Based on 2021 Annual Prospective Rate Report, provider office CIS-10 rate met the 66th percentile. Rate =44.24% (292/660). Cycle 2 (01/01/22- 03/31/22): data collection (claims/encounters) period to establish provider office rate for MY 2022 to pull new target list for office. 2) Q1 2022 results pending, reliant on Q2 2022 Statin Pharmacy data (slated for mid/late May 2022) to obtain results.	a1) Continue tracking members in need of diabetes screening test. a2) Continue prescribing provider outreach. b. CCS- For cycle 2 Provider Offices staff will still focus on outreaching to members to schedule cervical cancer screening but CalOptima plans to add a provider office staff tiered staff incentive that focuses on the number of completed cervical cancer screenings by June 2022. c. CIS Combo 10- Cycle 3 (04/18/22-06/30/22) Provider office received new target list of 677 members. Intervention includes, reconciling their target list, outreaching to members who are noncompliant, scheduling appointments and confirming if appointments were kept.	
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on **All LOB CCIPs** 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Helen Syn	QIC	ALL LOB CCIPs 1) Emerging Risk Health Coach Outreach OC CCIP 3 members, 1 Assigned, 1 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 46 members, 27 Assigned, 1 Unable to Contact, 3 No Longer Emerging Risk, 7 No Longer Eligible. 2) Q1 2022 results pending, reliant on Q2 2022 Statin Pharmacy data (slated for mid/late May 2022) to obtain results	1) Continue Emerging Risk Telephonic Health Coach Outreach 2) Continue SPD Statin quarterly mailers	
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals **OC and OCC** PPME and QIPEs 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Sloane Petrillo/S. Hickman/D. Hood	QIC	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs **1) PME (OC):** a) HRA's Initial: Jan 100% outreach completed; Feb results after 4/30 and Mar results after 5/31/22. Annual: Jan, Feb, and March with 100% outreach completed. b) HN MOC Oversight(Review of MOC ICP/ICT bundles) 100% of bundles returned were reviewed in 10 business day TAT for both Jan and Feb. March is pending. **2) QIPE (OCC):** a) HRA's Initial: Jan 99% outreach completed; Feb and Mar 100% outreach completed. Annual: Jan, Feb, and March at 99% outreach completed. b) ICP High/Low Risk CA MMP 1.5 goal is 75%: High risk 85% and Low Risk 78% for Q1 2022 c) CA MMP 1.6 Care Goal Discussion: Q1 2022 is 98% for both initial and revised ICP. d) ICP Completed within 90 days MMP 3.2: Q1 2022 is 85% e) HN MOC 100% of bundles returned in January were reviewed in 10 business day TAT; February 96% were reviewed within 10 business days. March data is pending. **3) LTSS HRA OCC:** Monitor for timeliness on outreach for completion. Quarterly monitoring.	**1)PME (OC):** a) HRA's Continue same process. b) HN MOC Oversight(Review of MOC ICP/ICT bundles) Continue same process. **2) QIPE (OCC)**: a) HRA's Continue same process. b) ICP High/Low Risk CA MMP 1.5 goal is 75%: Continue same process. c) CA MMP 1.6 Care Goal Discussion: Continue same process. d) ICP Completed within 90 days MMP 3.2: Continue same process. e) HN MOC Continue same process **3) LTSS HRA OCC:** Ongoing Process.	

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BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Natalie Zavala/Sheri Hopson	QIC	BHIIP: 5 provider groups submitted Q4 milestone reports, overall 97% of the targeted milestones were completed and reported to DHCS by 3/1/22. One provider group reported challenges completing milestones for Q3 & Q4 of 2021, and Q1 2022 and performance measures. The group selected new performance measures from an approved list provided by DHCS; MOU amended to reflect changes. A corrective action plan (CAP) was issued to address uncompleted milestones. CAP returned by 3/1 and reviewed by BHI and additional information requested. ABA P4V: Downloaded stats from Tableau to prepare the last ABA P4V report card for 2021. Requested Provider Relations to email the report cards to the providers by 2/2. Several discussions/meetings with medical director, sr reporting analyst, and P4V team to finalize the calculation methodology for the measurement year 2021 incentive payments.	BHIIP Q1 activities: 1) Prepare PY2 Q1 2022 milestone report for distribution in May to DHCS; 2) Review provider group's revisions to CAP and finalize; and 3) Prepare Q2 2021 incentive payment once received from DHCS expected in April. ABA P4V: 1) Prepare check request for the incentive payout by 3/31. 2) Discuss with ITS for report cards to be distributed bi-annually using the portal.	
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 addition of virtual outreach visits to shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Katie Balderas/S. Hickman	QIC	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19: Outreaches are virtual and telephonic to three shelters: Yale Navigation Center, Costa Mesa Shelter, and Huntington Beach Navigation Center. In contact with recuperative care facilities telephonically to coordinate care with members. 2)Primary point of contact for coordinating care with collaborating partners and HNs: Through the Homeless Respons Team phone line. 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19. Clinical Field Team has worked with clinics to support outreach services to encampments. 4) Clinical Field Teams had 109 dispatches with a total of 94 individuals treated in Q1 2022. We added two additional referral sources for the CFT program in Q1 Be well Mobile Crisis Unit and Huntington Beach Police Mobile Unit.	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19: Continue to look for additional opportunities for virtual and telephonic outreach to other shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs: Script will be implemented in Q2 to better track contacts. 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19. Continue to work with the county and other external partners to support their efforts at encampments. 4) CalOptima will continue to explore additional referral sources for the CFT program.	
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Sherry Hickman/**Gail McMillen**	QIC	1) HHP transition members outreach completed. 2)WPC transition members outreach nearly complete. POF member outreach has begun and between these three groups 660 members have had outreach and 183 enrolled. 3)DHCS reporting Creation and implementation of weekly ECM activity log with validation process for health networks. Internal submission expected on 5/6 for one time and quarterly implementation. 4) Oversight Strategey for CalAIM-Undetermined at this time. First of two round review completed.	1) HHP transition members ongoing management of enrolled ECM members. 2)WPC transition members ongoing management of enrolled ECM members. 3)DHCS reporting Ongoing monitoring of weekly ECM activity log to support reporting metrics. 4)Oversight Strategy for Cal-Aim: Once 2nd round of reviews completed, a decision on frequency of monitoring. 5) working POF list for outreach to potentially eligible members.	

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Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Katie Balderas/Marsha Choo	QIC	CalOptima issued an RFP in search of an NCQA consultant for both Health Plan Accreditation (HPA) as well as for Health Equity Accreditation (HEA). Standards for both HPA and HEA have been purchased. CalOptima launched a Health Equity Workgroup, developed a shared definition of Health Equity, and began developing a roadmap for advancing health equity that includes: 1) Making an explicit commitment to advancing health equity to internal and external stakeholders 2) Identifying existing and needed organizational assets, resources and leadership 3) Measuring health inequities and identifying impactful strategies focused on social determinants of health 4) Implementing short- and long-term strategies focused at the member, organizational and community level 5) Ongoing data collection, shared lessons and expanded capacity	NQCA consultant to be contracted and launch kick-off for both HPA and HEA. Next steps in the development of the Health Equity Framework include refining the overarching goals and creating more specific objectives.	
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW} to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	Marsha Choo/Katie Balderas/Kelly Rex-Kimmett	QIC	CalOptima Quality reviewed a draft of the 2022 DHCS Quality Strategy and provided feedback. DHCS' final draft has been submitted to CMS.	Educate other areas on the elements of the 2022 DHCS Quality Strategy and focus on incorporating and aligning these elements with our QI Workplan.	
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	**[NEW} to 2022 QI Work Plan** SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.	Natalie Zavala	QIC	1) Met DHCS deadlines: submitted Letter of Intent (LOI) to participate in SBHIP in January; submitted SBHIP Partner form in March. 2) Provided update at Special Joint MAC and PAC Meeting on March 10th. 3) Continued weekly internal meetings with Core Team. 4) Continued bi-weekly collaboration meetings with Orange County Department of Education (OCDE).	1) Meet with school districts on April 19th to review expectations and begin assessment phase of program. 2) Hold stakeholder workgroup in May. 3) Provide SBHIP update at WCM CAC 5/17.	
II. QUALITY OF CLINICAL CARE- Adult Wellness							
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	Helen Syn	QIC	1a. 2022 Member Health Rewards processed as of 3/31/22: BCS: 81 for MC and 2 for OCC; CCS: 149 for MC; COL: 1 for OC 1b. Transition to Member Health Reward Vendor Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2. Pending complete transition to member health reward vendor to define and set deadlines to implement. 3. Member Engagement Strategy:Texting: CCS texting campaign total= 11,512 IVR: CCS Total 2,800= 2,239 Message Left + 561 Message played; COL Total 512= 344 Message Left + 168 Message played Social Media: CCS Static Social Media Post; COL Static Social Media Post Digital Ad: CCS digital ad; COL digital ad Direct Mailing: 67,079 CCS MC member mailing; 17,069 BCS MC member mailing Community Connections: CCS article 4. Community Events: Mobile Mammography: KCS event 12 CCN members completed 5. 2022 February Prospective Rates (PR): Breast Cancer Screening MC: 44.42%, OC: 52.57%, OCC: 50.41% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 43.77% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 35.6%, OCC: 38.53% Measure is performing higher than same time last year for both OC/OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Complete transition to member health reward vendor is set to be executed by August 2022. 2. Targeted member engagment and outreach campaigns to identified zip codes. 3. **Member Engagement** Texting: BCS texting campaign scheduled in May IVR: BCS scheduled for Q3/Q4 Social Media: BCS scheduled for Q3/Q4 Digital Ad: BCS scheduled Print Ad: COL scheduled Q2, BCS scheduled Direct Mailing: COL scheduled for Q2; CCS, BCS, COL scheduled for Q4 Community Connections: Article scheduled for Q2/Q4 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue Live Call Campaign: Pending new contract 4. Community Connections: Ongoing mobile mamography events	

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COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	Helen Syn	QIC	1. COVID texting campaigns continued in Q4 2. COVID community vaccine events were held in partnership with OCHCA ongoing. 3. Vendor has processed a total of 604,521 incentives (cumulative) •PHM has processed a total of 133,572 incentives (cumulative). This total includes incentives processed in-house & through vaccine events. •Vaccine Events: ☐January 15th: 346 ☐January 22nd: 165 ☐February 19th: 170 ☐March 12th: 71 ☐March 19th: 85 ☐March 26th: 37 ☐Total vaccine events: 874 ☐As a reminder, the breakdown of the vaccine event totals may be different to the numbers reported by Community Relations. Community Relations totals represent all CalOptima members vaccinated and PHM numbers represent all that were handed a gift card. 4. VIP reimbursement data set provided to DHCS for First Submission. 5. VRP responses to DHCS coordinated by COVID Vaccination Workgroup	Texting campaigns continue. New texting messages will be updated to include expanded age ranges and booster shot eligibility. Ongoing COVID messaging to go out in Member Newsletter and Provider Newsletters about the importance of boosters and new eligibility with expanding age sets. COVID vaccine incentive processing continues, CAIR registry data and logic improvements to assist with identification and more timely processing. COVID vaccine events with OCHCA continue Future Vaccine Events: April 9th: 67, April 16th: 54, April 23rd: 42, May 17th , June 7th	

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III. QUALITY OF CLINICAL CARE- Behavioral Health							
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:34.67 %	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	Natalie Zavala	QIC	PR HEDIS Rates Q1 (February): 30 day- 16.67%, 7 day- 16.67%; BHI real-time report Jan-March: 30 day- 44%, 7 day- 29%. 1) Continued outreach to members post-discharge to coordinate follow-up appointments. Difficulties included: members not attending follow-up appointments due to readmission; member declining assistance; and inability reaching members due to invalid phone numbers. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those who are not attending follow-up appointments within 7 days of discharge.	
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	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	Natalie Zavala	QIC	PR HEDIS Rates Q1 (February): Initiation Phase- 41.04%, Continuation and Maintenance Phase- 59.57% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member f/u visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Created and submitted tip sheet on Treatment for Children with ADHD to communications for CalOptima Member Spring Newsletter.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Update data collection for compliant and non-compliant provider letters. 3) Distribute non-compliant provider letters.	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	**[NEW} to 2022 QI Work Plan** 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	Natalie Zavala	QIC	PR HEDIS Rates Q1 (February): M/C: 20.73%, OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' primary care physician (PCP) name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Difficulties: attaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing.	1) Continue tracking members in need of diabetes screening test. 2) Continue prescribing provider outreach.	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	**[NEW] to 2022 QI Work Plan** 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	Natalie Zavala	QIC	PR HEDIS Rates Q1 (February): 30 day- 24.94%, 7 day-16.12% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance.	1) Develop report on member ED visits to identify trends. 2) Attend at least 1 HN Quality meeting to discuss/ address barriers.	

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IV. QUALITY OF CLINICAL CARE- Chronic Conditions							
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2021** HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	Helen Syn	QIC	1a) HbA1c Test Health Rewards: 13 Processed, 9 approved, 4 denied 1b) Transition to Member Health Reward vendor. Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2) Diabetes A1C member mailers MC 7,803, OC 84, OCC 637 = 8,524 mailers Emerging Risk Health Coach Outreach: MC 185 Assigned, 3 No Longer Eligible, 4 No Longer Emerging Risk, 1 Opt Out, 3 Unable to Contact OC 3 members, 1 Assigned, 1 No Longer Eligible. OCC 46 members, 27 Assigned, 1 Unable to Contact, 3 No Longer Emerging Risk, 7 No Longer Eligible. 3) Member Engagegment Strategy: Texting: CDC texting campaign content submitted to DHCS for approval, currently under review. IVR: Campaign content completed and approved, pending launch date. Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures. 5) 2022 February Prospective Rates (PR): There were no A1C Testing rates for Feb 2022 PR A1C Adequate Control <8.0 MC: 1.99%, OC: 1.82%, OCC: 2.81% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). A1C Poor Control >9 MC: 97.98 %, OC: 98.00%, OCC: 96.81% Measure is performing better for all LOBs than same time last year (lower rate is positive trend) and below the 50th percentile (MPL).	1) Track and monitor until the end of member incentive year. Complete transition to member health reward vendor is set to be executed by August 2022. 2) Continue the Emerging Health Coach outreach to the end of 2022. 3) Texting: Pending DHCS approval launch date slated for Q4 2022. IVR: Approximate launch date slated for end of June 2022. Social Media: Campaign slated to launch Q3-Q4 2022.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	Helen Syn	QIC	1a) Eye Exam 5 Processed, 5 approved, 0 denied 1b) Transition to Member Health Reward vendor. Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2) Diabetes Eye Exam member mailers MC 7,803, OC 84, OCC 637 = 8,524 mailers 3) Member Engagegment Strategy: Texting: CDC texting campaign content submitted to DHCS for approval, currently under review. IVR: Campaign content completed and approved, pending launch date. Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures 5) 2022 February Prospective Rates (PR): Diabetes Eye Exams MC: 26.65%, OC: 35.45%, OCC: 35.32% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). 6) Identified VSP data fields needed from HNs for data sharing criteria.	1) Track and monitor until the end of member incentive year.Complete transition to member health reward vendor is set to be executed by August 2022. 2) Analyze if a need for additional member mailers are necessary. 3) Texting: Pending DHCS approval launch date slated for Q4 2022. IVR: Approximate launch date slated for end of June 2022. Social Media: Campaign slated to launch Q3-Q4 2022. 6) Submitted ticket to IS on 3/31/2022. Slated for completion Q2 2022.	
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx.	There are four parts to this multidispclinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.	Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson	QIC	Planned activities being revisted for revised proposal and will pend approval by CMO/BOD	Planned activities being revisted for revised proposal and will pend approval by CMO/BOD	

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V. QUALITY OF CLINICAL CARE- Maternal Child Health							
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	Ann Mino/Helen Syn	QIC	1) Member Health Reward for Postpartum care has been agreed by the business owners to not transition to the Health Reward Vendor due to the small volume and complexity of processing. 2) Process for the first quality Initiative mailing is being finalized. First mailing is projected to go out in Q2 2022. Mailing will target members that recently delivered and encourage timely postpartum care. Prenatal care article included in the Spring 2022 Medi-Cal newsletter, healthcare chat video on prenatal visits on immunizations on social media platforms, and social media posts related to prenatal/postpartum care. 3) Provider communication on Postpartum Care Extension. 4) Bright Steps Program conducted initial outreach to 1793 unique members. 1034 outreach attempts made to 623 for postpartum members, 238 postpartum assessments completed. 5) Total # of PPC health rewards approved for Q1: 63. 6) Planning for Diaper Day events in collaboration with CalFresh and community partners is continuing. Tentative schedule is being created for community events to take place in Q2 2022. 7) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. February 2022 Prospective Rates: Timeliness of Prenatal Care: 80.49% Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 53.16%. Measure is performing higher than same time last year and has not met the 50th percentile.	1) Postpartum quality initiative mailing is projected to begin Q2 2022. 2) Prenatal and postpartum social media campaign is projected for Q2 2022. 3) Diaper Day + CalFresh community events to promote Bright Steps. 4) Medi-Cal newsletter article on postpartum care articled in Medi-Cal summer newsletter. 5) Postpartum Care Extension newsletter article in Medi-Cal summer newsletter.	
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness							
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2021** Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	Helen Syn	QIC	1) Targeted member engagement and outreach campaigns in coordination with health network partners.- Well-C	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 0-2 Newsletter, Well-Child Visits Flyer and Lead Poisoning Fact Sheet mailing slated for April 2022 - Targeted ad campaign for Well-Care Pediatrics and Immunizations via digital and social media - April World Immunization Week observance on social media - Community Connections April Newsletter for World Immunization Week observance - Medi-Cal member newsletter article on adolescent immunizations - Live call campaign for mi-year push for well-child and immunization measures. 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics - Attend community events targeting the pediatric and adolescent population. - Plan back-to-school vaccination events. 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures	
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2021 Goal (3 Year Goal)**: Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	Helen Syn	QIC	1) Shared report in January 2022 to health networks with Q4 2021 data on members that have not been screen as recommended for blood lead screening. Worked with ITS to leverage new provider portal and share blood lead screening report with CCN providers. Report to CCN is on track for Q2 2022. Beginning the implementation process for a health network attestation to ensure that HNs are sharing member detail blood lead reports with their providers. 2) Member education efforts: blood lead screening campaign on social media in March 2022, blood lead article in Medi-Cal newsletter in Spring 2022. 3) Prop 56 provider value based payments for Blood Lead Screening. February 2022 Prospective Rates Lead Screening in Children (in 2022 became an MCAS measure that will have to meet MPL). MC: 49.25% Measure is performing lower than the same time last year and has not met the 50th percentile (MPL).	1) Provider communication on blood lead screening testing and management through communication platforms, including Health Network Qualify Forum. 2) Blood Lead Screening report sharing to CCN Providers.	

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VII. QUALITY OF SERVICE- Access							
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	Marsha Choo/Jennifer Bamberg/Maggie Hart	MEMX	The function of recruiting providers transitioned from Provider Relations to Contracting Department. In addition, the staff identified for recruiting providers has been on FMLA.	CalOptima is currently engaged in a provider onboarding end-to-end process led by Process Excellence that includes a review of the provider recruiting process and workflow.	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	Marsha Choo/Jennifer Bamberg	MEMX	In Q1, the Provider Directory Validation Template was being revised and a new format has now been implemented which PR began using in Q2.	Provider Relations is now requesting PCPs and SCPs open panels during Provider Data Validation on a quarterly basis.	
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	Marsha Choo/Jennifer Bamberg	MEMX	1) No update for Q1 but non-compliant letters issued to providers last fall, in Q4-2021. 2)PDSA issued to 12 HNs for not meeting Timely Access Standard in January 2022. Networks are required to complete 3 separate PDSAs: •Improve Member Access to PCPs •Improve Member Access to Specialists •Improve Telephone Access to Medi-Cal pop. •Technical Assistance calls held February 2022 •Reviewed and approved "Plan" section of PDSAs	1) Final results from 2021/22 Timely Access survey due by July. Review and issue corrective acction to individal providers not meeting timely access standards 2) A&A workgroup to review HNs final PDSA submissions due in June and provide final status and feedback: Completed, Closed, or Other	
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After 3 Attempts** from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	Marsha Choo/Jennifer Bamberg	MEMX	1) In Q1, the Provider Directory Validation Template was being revised and a new format has now been implemented which PR began using in Q2. 2) Awaiting 2021/22 Timely Access Survey results from vendor with estimated arrival date in July.	1) Provider Relations has 9% or 115 contracted TINS (780 unique providers) validations to date. Provider Relations and Provider Data Management Services (PDMS) continues to complete analysisand update the system of record for the Monthly and Quarterly Provider Data Quality Checks/Audits. 2) Review survey results in summer, and issue letters of noncompliance based on the following escalation order: •Education (1st yr of non-compliance) •Warning (2nd yr ...) •Escalation (3rd yr...)	
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	Marsha Choo/Jennifer Bamberg	MEMX	Network Adequacy Standards: **Medi-Cal Plan Level:** •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met **Medi-Cal HN Level:** •Mandatory Provider Types: Not Met. (Certified Nurse Midwives and Licensed Midwives) •Provider to Member Ratios: ○PCPs: Met ○Specialists: Not Met •Time/Distance: Not Met **Medi-Cal Timely Access:** •PDSAs issued to 12 HNs for not meeting Timely Access Standard - January 2022 •Continue to field 2021/22 Timely Access Survey	Continue to monitor quarterly If Net Adequacy standard (s) not met, outreach to network to directly. Review HNs final submission for PDSAs in June. Continue to prep for new 2022 Timely Access Survey with target fielding dates, June-November	

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VIII. SAFETY OF CLINICAL CARE							
Plan All-Cause Readmissions (PCR)	**HEDIS MY2021** Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving incteased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regardign the importance of having a post dischage visit with the members PCP.	Mike Shook	QIC	No update. Current initiative specific to MC LOBs only	Need follow up meeting to be scheduled to further discuss	
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) To reduce the number of nosocomial infections for LTC members. 2) To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses will be visiting each facilitiy/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofor (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	Michelle Findlater/Scott Robinson	QIC	The HAI scores trended upward in Q4 of 2021, and then had a slight downward trend in Q1 however we are still over a point above the average which is now 4.51 Invoice submission for CHG and Iodophor increase in Q1 however we continue to see nearly 1/3 of the invoices not being submitted per program requirements Of the submitted invoices, we continue to see that more than 50% are not purchasing even half the amount needed to complete the bathing and Iodophor protocols	The PIPQI Program was set to run out its funding in March 2022. The PIPQI Team took and extension to the Board in April 2022. Extension asked for additional $275,000 to extend program through the end of the fiscial year 21-22. New budget based on removing $7500 quarterly incentive Reduce baths from every other day to 2 per week and offer product reimbursement based on that reduction Remove 6 least complaint facilities	
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities; toolkit, consultative services and webinars provided to all Orange County nursing homes free of charge	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2022. Planned activities include: 1) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 2) Provide guidance, protocols for preventing spread of COVID 3) Support training on how to stock and use protective gear 4) Develop high compliance processes for protection of staff and residents. 5) Make toolkit available for free at www.ucihealth.org/stopcovid 6) Provide COVID prevention helpline to offer guidance and information to nursing home staff 7) Conduct point prevalence sweeps of residents for multi-drug organisms	Cathy Osborn/**Scott Robinson**	QIC	**UCI provided:** 1. Consultative service: 12 nursing homes received intensive trainig with weekly feedback of staff saftey metrics; 31 additional OC nursing homes received phone consultation services. 2. Confidential helpline for COVID questions and inquires: To date, 250 helpline inquires have been addressed. 3. Point prevalence sweeps of residents and staff. 4. Monthly progress meetings with CalOptima.	UCI is on track to successfully complete project by 5/31/2022. 1. UCI will continue to provide education to nursing homes. 2. UCI will continue to coduct point prevalence sweeps of residents for multidrug-resistant organisms and analyze results.	

Board of Directors' Quality Assurance Committee Meeting
September 14, 2022

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
Second Quarter 2022 Meeting Summaries

May 31, 2022: PACE Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary Health Plan Monitoring Data and PACE Quality Initiatives

- All PQIC members present
- Infection Control Subcommittee: PACE's Response to COVID-19:
    - Staff and participants continue to wear mask inside the PACE center and screen their temperature at front door.
    - PACE staff must be fully vaccinated (with booster) or tested weekly in outside facility.
    - Prts must also have their COVID vaccine and booster to attend day center; those without booster dose yet must be tested using rapid antigen before receiving services in the center.
    - Continue to schedule prts for COVID vaccinations at retail pharmacies like CVS and Mercy Pharmacy. Vaccination status tracked and monitored by QI. 97% of prts have received initial doses, 88% of eligible prts have received a booster dose; 2% of eligible prts have received the 2nd booster dose (4th dose).
    - Continue to use telehealth modalities for prt encounters, when appropriate.
    - All new cases of COVID reported to CalPACE, NPA, and CMS and daily telehealth follow up by providers (PCP f/u on symptom improvement and O2 levels).
    - New Treatment- Paxlovid oral antiviral
    - Continue to follow State and local guidance regarding COVID safety updates.
- Presentation of Q1 2022 HPMS Elements:
    - Enrollment. Figures presented. Drop in terms of total membership due to disenrollment. As in previous trends, months with high enrollments were subsequently followed by large disenrollment. Overall turning in the right direction. Covid waves also impacts withdrawals in programs like PACE. Q1 ended with 417 total enrolled.
    - Immunizations

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        - Pneumococcal Immunization rate is at 95%. Goal of 94% has been met.
        - Influenza rate is at 91%. Goal of 94% was not met. 22 refused, some reasons of refusal were due to not wanting to overlap the flu shot with other vaccines received.
        - Covid-19 Immunizations is at 97%. Goal of 95% has been met.
    - Falls without Injury. Q1 ended with 74. Up from 61 in Q4 of 2021. Center manager noted that it is due to prt's not using DME. Action plan is to grow in maintenance program to retain prt's strength.
    - Grievances. Decreased from 12 from 2021 Q4 to 4 in Q1. 2 were transportation related. Improvement has been noticed since all transportation grievances are now sent to Secure for them to review and resolve.
    - Emergency Room Visits. 84 ER visits, a decrease of 4 from Q4 2021. 40 were d/c to home without hospital admission. 44 admitted to hospital.
    - Medication Error Without Injury. 1 Medication Error w/out Injury in Q1 2022. On 2/14/22 a PACE provider medication for the wrong participant. Staff notified participant of error and the medication arrived at Participant' s home but was discarded without being ingested. No injury occurred. Action taken was staff education.
    - 2022 Q1 HPMS Quality Indicators
        - Enrollment Data – 417 total enrolled
        - Immunizations – Pneumococcal, Influenza
        - Falls Without Injury-74
        - Denials of Prospective Enrollees - 0
        - Appeals - 0
        - Grievances- 4
        - Emergency Room Visits- 84
        - Medication Administration Errors - 1
    - Quality Incidents with RCA
        - Falls with Injury – 9
        - Elopements – 0
        - Burn – 3
        - Pressure Ulcer - 1
- Presentation of Q2 2022 PACE Quality Initiatives
    - COVID-19 Vaccine Booster Quality Initiative. Goal was 80% booster dose. 82% of eligible prts received a booster dose (3rd dose of vaccine). Goal Met. Though not a part of the original quality initiative, 4th doses of COVID vaccine are now recommended for ALL PACE participants 4 months after 3rd dose of vaccine. PACE provides assistance with

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scheduling and transportation for vaccinations and continue to track vaccine status.

- Telehealth Engagement Quality Initiative. Goal for 2022 is that ≥ 66% of members will be able to engage in telehealth visits by having telehealth access such as VSEE, Google Duo or Facetime capabilities. Currently at 55%. Telehealth engagement is decreasing. Q1 more participants attending in person, able to be seen at PACE.
- Advanced Health Care Directive. Q1 ended 41%, goal is 50% by end of 2022. This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team. Will make it a priority in the remainder of 2022 once Social Work team is fully staffed.

June 28th, 2022: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- All PQIC members present
- Membership. Figures presented. Overall, the capacity of the Marketing and Enrollment to continue to enroll despite the COVID restrictions. November – January are the strongest months in terms of Enrollment. Hoping to continue to enroll 8-10 prts per month. Q1 ended with 417 total enrolled.
- Presentation of the Quality Work Plan Elements
  - Elements 3 – 5: Immunizations.
    - Influenza rate is at 91%. Goal of 94% was not met. 22 refused, some reasons of refusal were due to not wanting to overlap the flu shot with other vaccines received. The defining factor of not meeting the goal is due to the 22 refusals.
    - Pneumococcal Immunization rate is at 95%. Goal of 94% has been met. According to Dr. Tony Nguyen, PACE will be implementing the PCV20 (one shot), if this continues, then the rate will go up quacking and more compliant. TruChart has been updated to include the PCV20.
    - Covid-19 Immunizations is at 97%. Goal of 95% has been met.
  - Element 6: POLST. Goal has not been met at this time. Goal is 95%. In Q1, 90% of prts have POLST added to their chart.
  - Elements 7 – 9: Diabetes Care.

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        - Blood Pressure Control. Goal is 81.50% having a blood pressure of <140/90mm. Rate is 73%. QI has a list of prts whose blood pressure is above 140/90.
        - Diabetic Eye Exams. Goal of 82.77%. Rate is 95%. Goal met.
        - Nephropathy Monitoring. Goal is 98.30%, Rate is 100% in monitoring Diabetes patients.
    - Element 10: Osteoporosis Treatment. Goal of 90%. Rate is 97% of prts with Osteoporosis receiving treatment.
    - Element 11: Falls at Home classified as CMS Reportable Quality Incidents. Falls those results in fracture, hospitalization, and death. Q1 ended with 9, with a Rate of 49, well below the Goal of <207 per 1000 prts per year.
    - Elements 12 - 13: Potentially Harmful Drug/Disease Interactions in the Elderly.
        - Dementia - Goal is <27.24%. Rate is 17%. Pharmacy is keeping tight control of what is being prescribed to the Dementia prts.
        - CKD – Goal is <3.47%. Rate is 3%. 1 prt brought the rate from 0% to 3%.
    - Element 14: Decrease the Use of Opioids at High Dosage. Goal: 100% of members receiving opioids for 15 or more days at an average milligram morphine dose of (MME) 90mg will be reevaluated monthly by their treating provider. Met goal. One participant is receiving a dose greater than 90 MME and had PCP follow up each month in Q1 2022.
    - Element 15: Medication Reconciliation Post Discharge (MRP). Goal is 90% within 15 days. Rate is 100%.
    - Element 16: Access to Specialty Care. Goal is 85% to be scheduled within 14 business days. Rate went up from 87% in 2022 Q1 to 91% in Q2 2022.
    - Element 17: Telehealth Access. Goal is >=66%. Rate is 54%. List of prts who have notification in their chart that they do not currently have access is available. According to Monica, we are to going to see a huge decline in VSEE/Telehealth Engagement because prts are being seen in person and Clinic is starting to reopen.
    - Element 18: Acute Hospital Days. Goal was raised to <3,330 in 2022. In Q1, bed days decreased to 3389 from 4044, came very close in meeting the new goal. Quarterly Rate of Bed Days decreased from 945 (Q4 2022) to 763 (Q1 2022).
    - Element 19: Emergency Room Visits. Increase Goal to 850 emergency room visits per 1000 per year. Rate is 833. Goal met.

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- Element 20: 30-Day All Cause Readmissions. Reduced goal from <15% to 14%. Rate is 16% goal was not met. 3 to 4 prts have recurring admissions within the quarter.
- Element 21: Long Term Care Placement. Goal is <4%. Rate dropped to 1.4%. About 7 prts.
- Element 22: Enrollment Conversion. Goal is 60%. Rate is 79%. Goal met.
- Element 23: Transportation <60 minutes. Goal that 100% of trips will be less than 60 minutes, goal of 100% met.
- Element 24: Transportation on Time Performance. Based on the data from Transportation, 100% in Jan, 99% in Feb and March 2022. Ontime performance is within 15 minutes of pick-up time. Transportation Manager is in the process of being hired.

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Member Trend Report
2nd Quarter 2022

Quality Assurance Committee Meeting

September 14, 2022

Tyronda Moses, Director, Grievance and Appeals

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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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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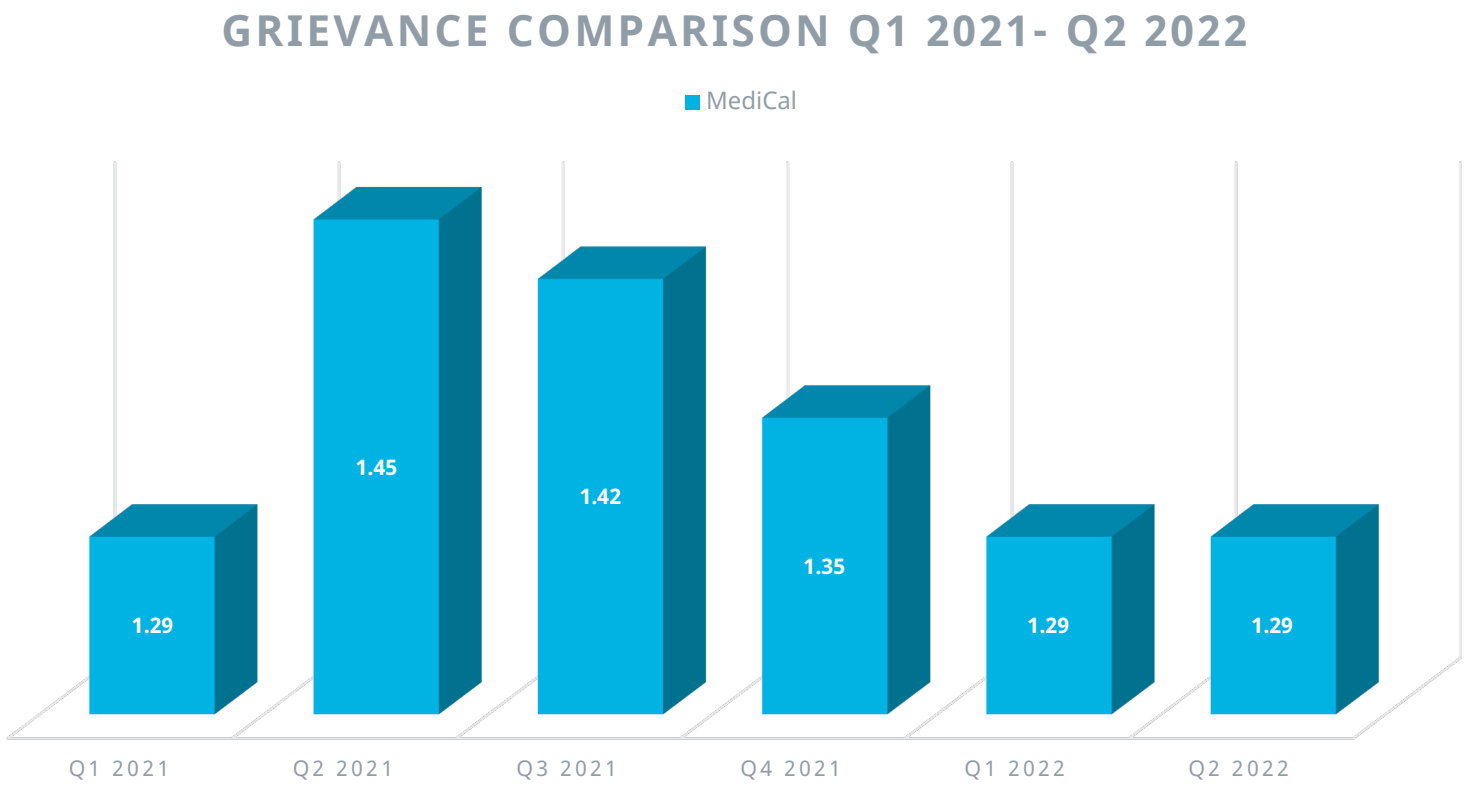
CalOptima Health

Medi-Cal Total Grievances – Per 1,000/MM



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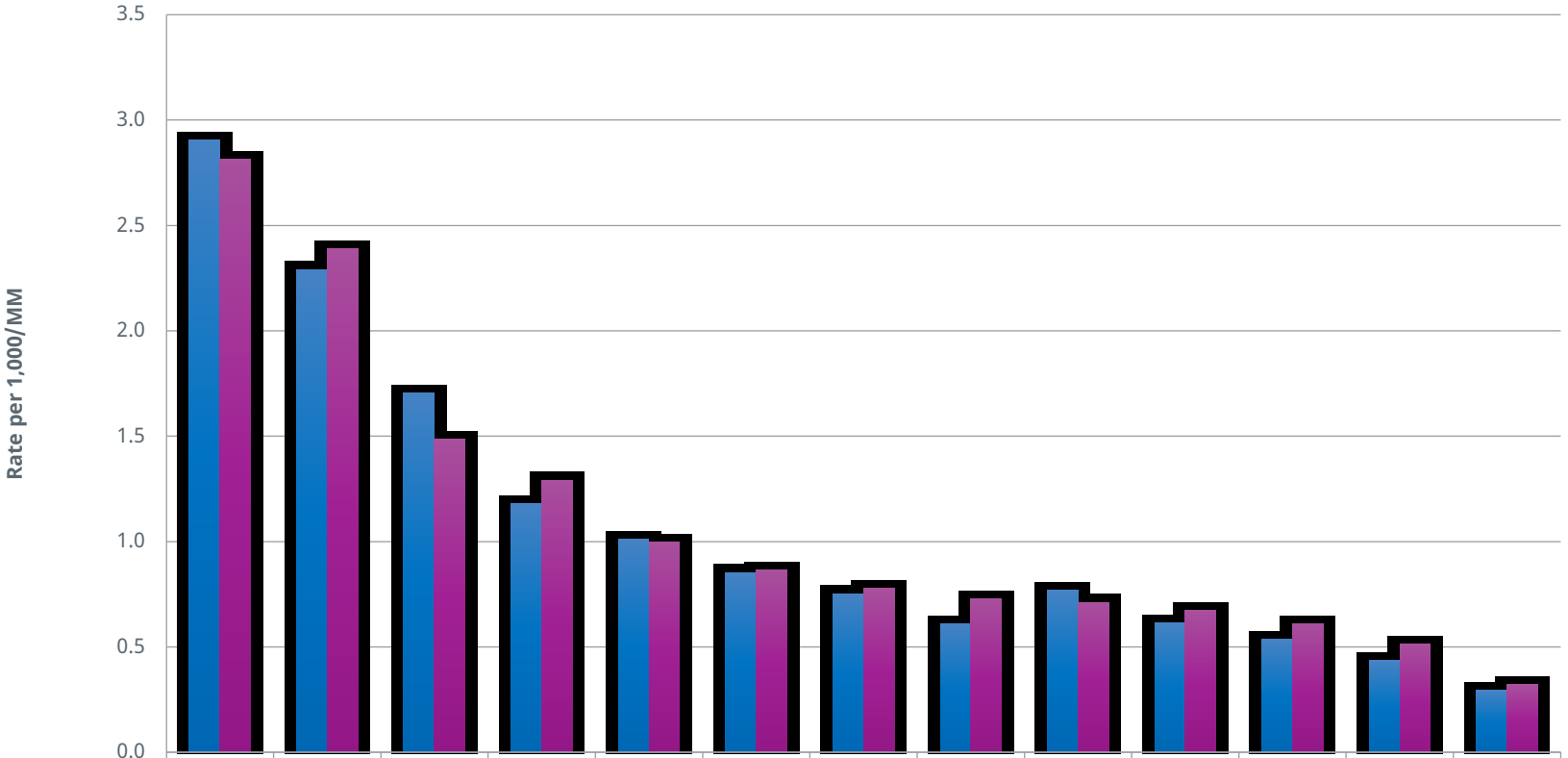
Medi-Cal
CalOptima Health

Medi-Cal Member Grievances (Rate per 1000)



	CCN (109,735)	Kaiser (55,742)	Monarch (97,220)	Heritage (8,184)	Talbert (30,588)	Prospect (41,362)	COD (105,809)	UCMG (41,510)	Arta (64,515)	AltaMed (55,948)	Noble (21,203)	Family Choice (47,373)	AMVI (27,234)
Q1-22 (3371)	2.90	2.29	1.70	1.18	1.01	0.85	0.75	0.61	0.77	0.61	0.53	0.44	0.29
Q2-22 (3483)	2.81	2.39	1.49	1.29	1.00	0.86	0.78	0.73	0.71	0.67	0.61	0.52	0.32

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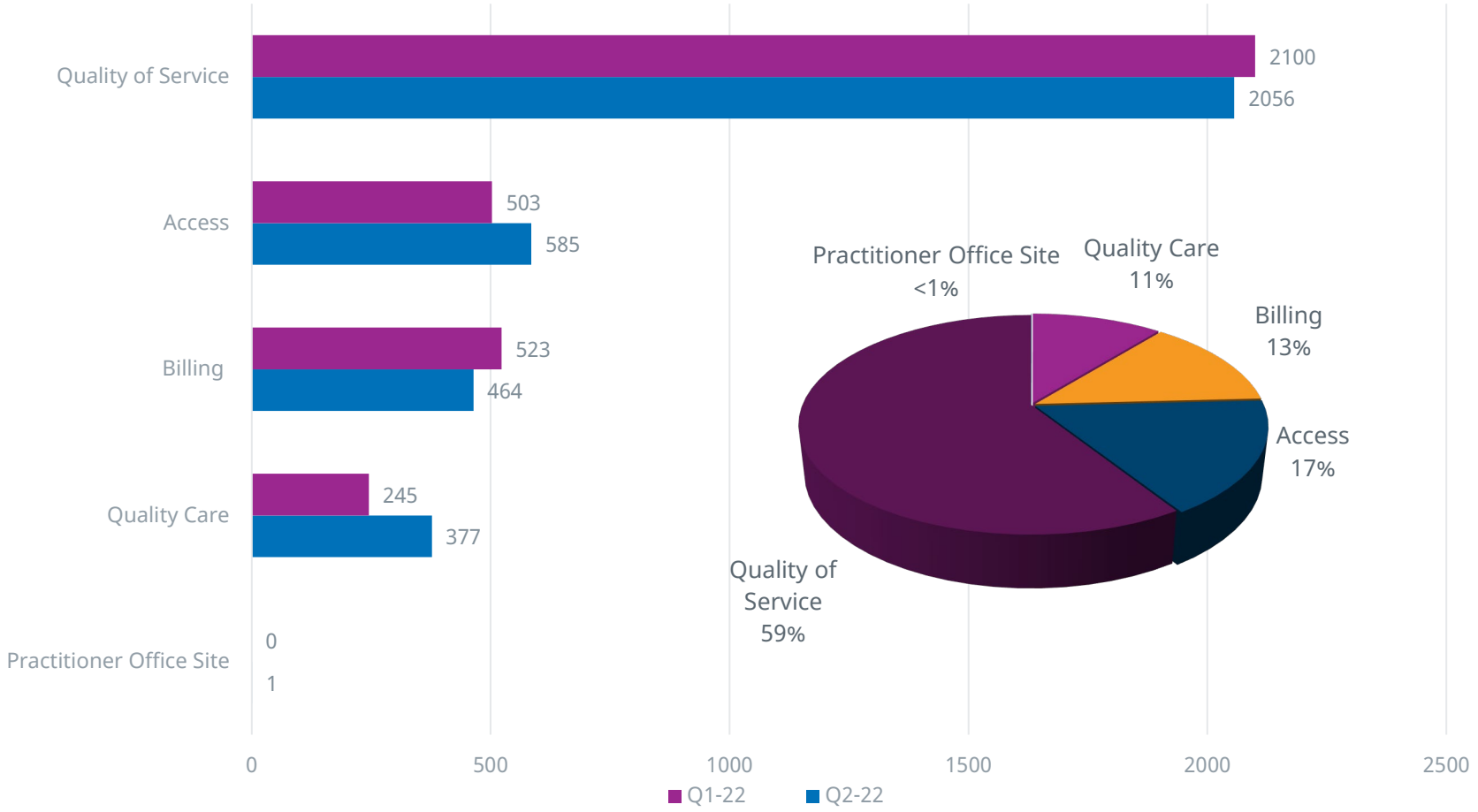
CalOptima Health

Medi-Cal Member Grievances by Category



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Grievance Trending
Medi-Cal Member Grievances Q2

- Delays in referrals by Plan or Provider
- Transportation – delays in pickup, driver service issues and no shows
- Unable to schedule timely appointments
- Quality of Services (concerns with treatment and/or diagnosis) – Provider Services
- Member billing concerns – ER service bills and member reimbursement request

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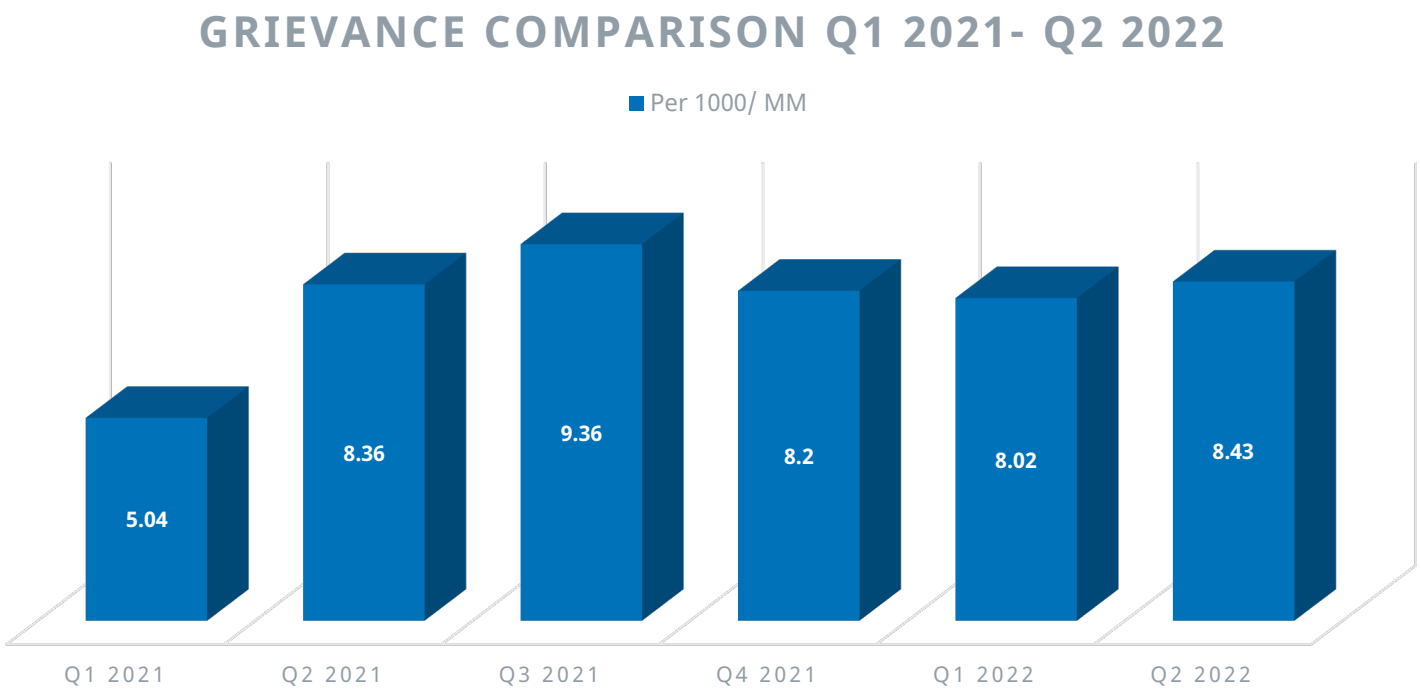
Medi-Cal
CalOptima Health

OneCare Connect Total Grievances – Per 1,000/MM



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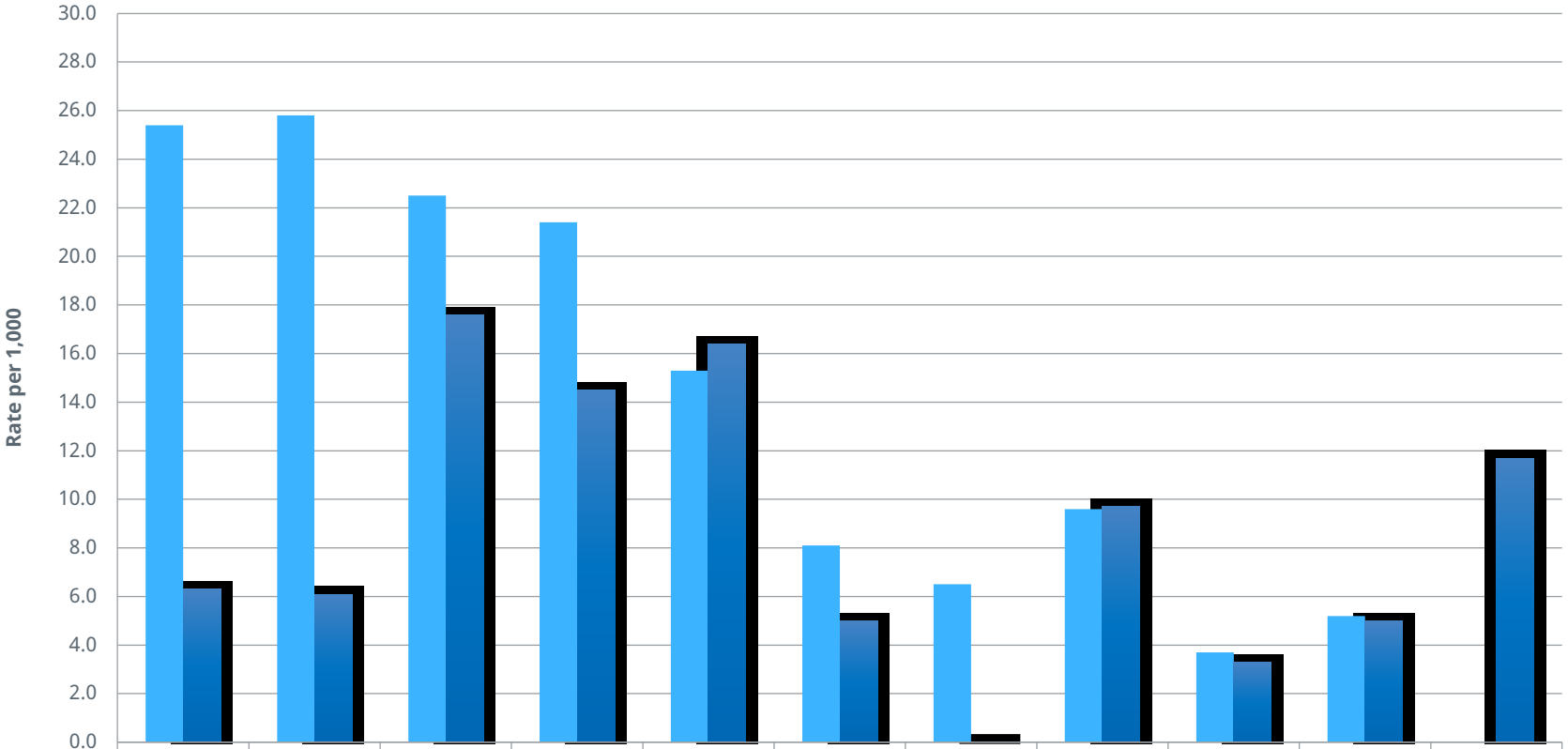
OCC HN Member Grievances



	Alta Med Health (625)	Talbert (1,180)	Monarch (4,608)	CCN (2,247)	Prospect (2,083)	Arta (640)	UCMG (641)	Heritage (210)	Family Choice (1,914)	AMVI Care (399)	Noble (363)
Q1-22 ()	25.4	25.8	22.5	21.4	15.3	8.1	6.5	9.6	3.7	5.2	0.0
Q2-22 ()	6.3	6.1	17.6	14.5	16.4	5.0	0.0	9.7	3.3	5.0	11.7

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CalOptima Health

Trends: OCC Grievances

- Grievances increased 4.7%, from 356 in Q1 to 373 in Q2 2022.
- Grievances were due to the following:
  - Transportation – no shows/late pickup
  - HN/PMG – delays in authorization or incorrect authorizations
  - Provider/staff – demeanor and inconvenience
  - CalOptima staff – GARS, CS, Weekend CS, Case Management
  - Delays and availability of appointments and/or treatment or care
  - Questions/Concerns with treatment

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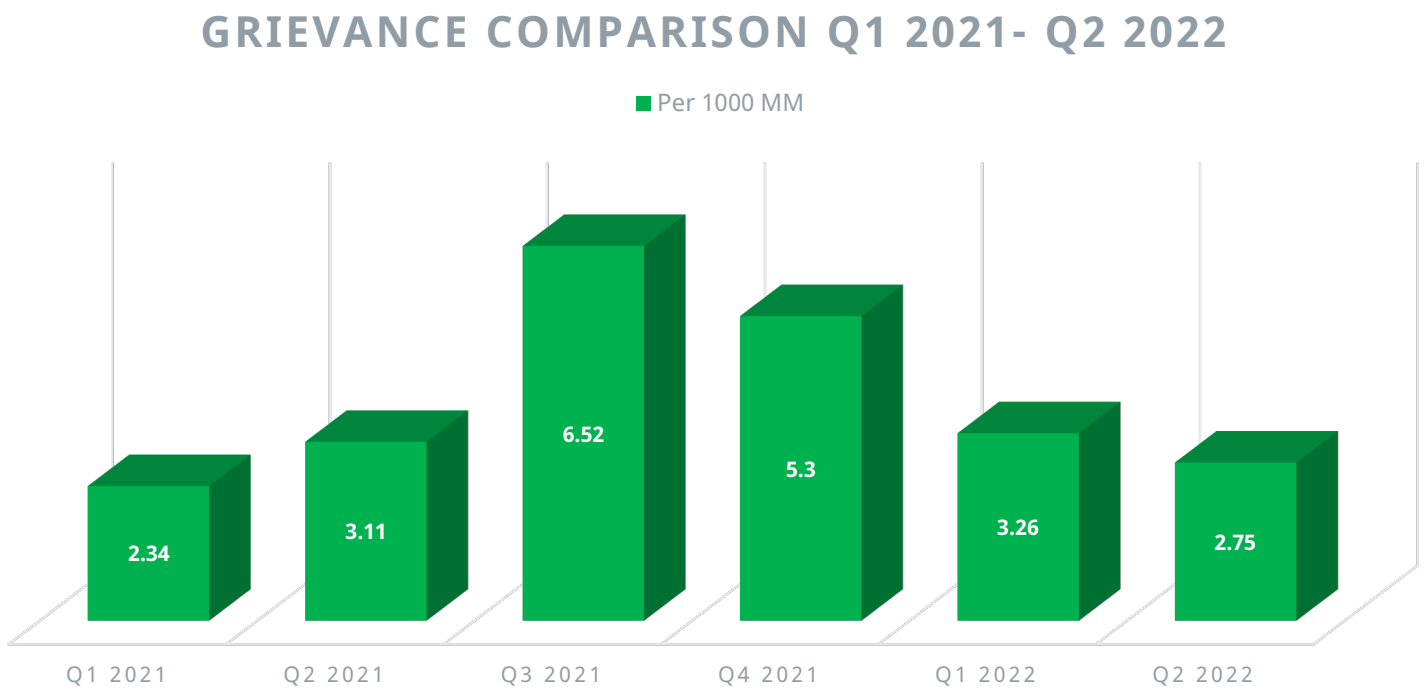
OneCare Total Grievances – Per 1,000/MM



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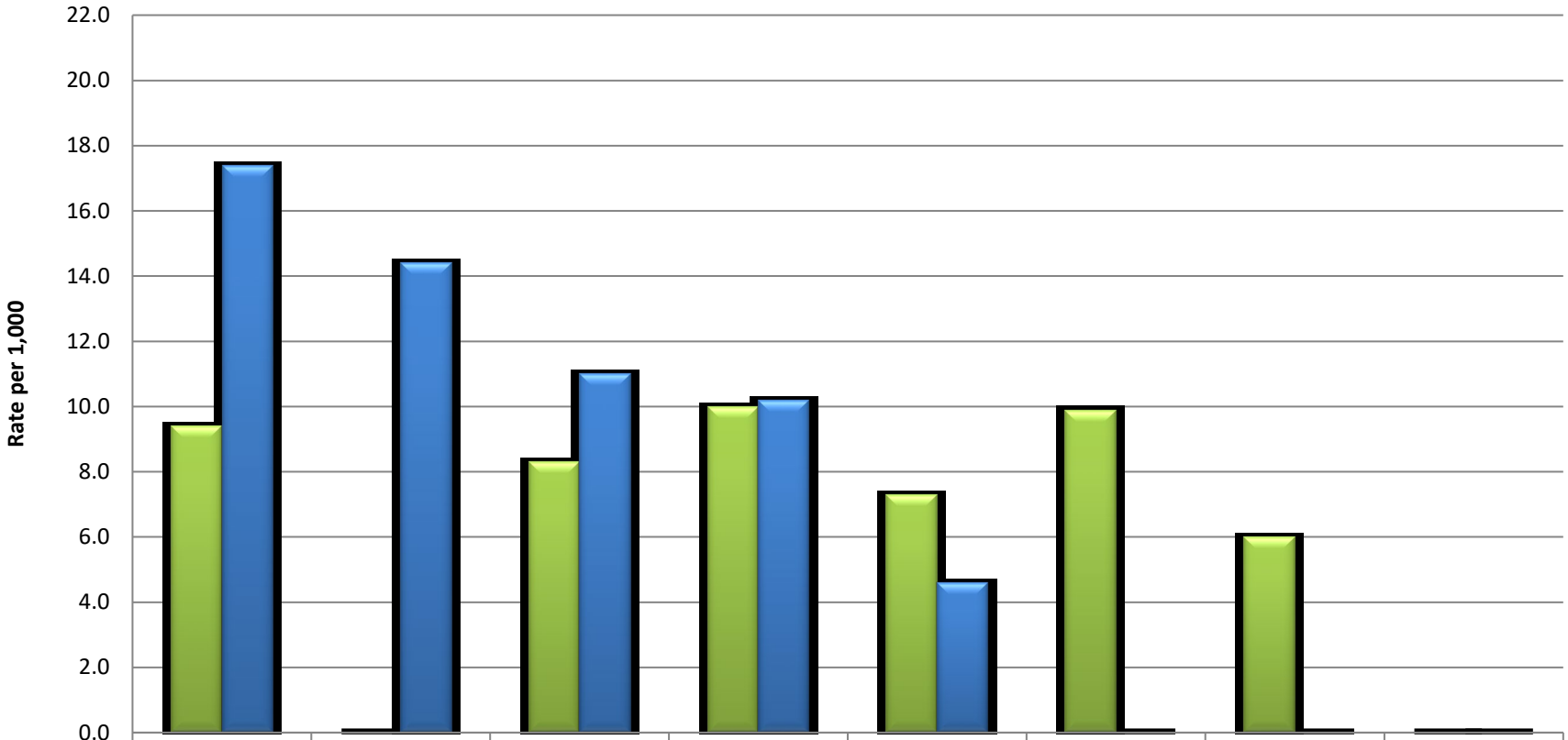
OC HN Member Grievances



	Arta Western (212)	UCMG (126)	Talbert (242)	Monarch (999)	AMVI/ Prospect (412)	Alta Med Health (202)	Family Choice (167)	Noble (31)
Q1-22 ()	9.4	0.0	8.3	10.0	7.3	9.9	6.0	0.0
Q2-22 ()	17.4	14.4	11.0	10.2	4.6	0.0	0.0	0.0

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OneCare CalOptima Health

Trends: OC Member Grievances

- Grievances decreased 8.3% from 24 in Q1 to 22 in Q2 2022.
- Grievances were due to the following:
  - Transportation – no shows/late pickup
  - HN/PMG – auth cancelled without notification
  - Provider/staff – demeanor and inconvenience
  - CalOptima staff – demeanor
  - Long wait times – services and care

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Appeals Summary

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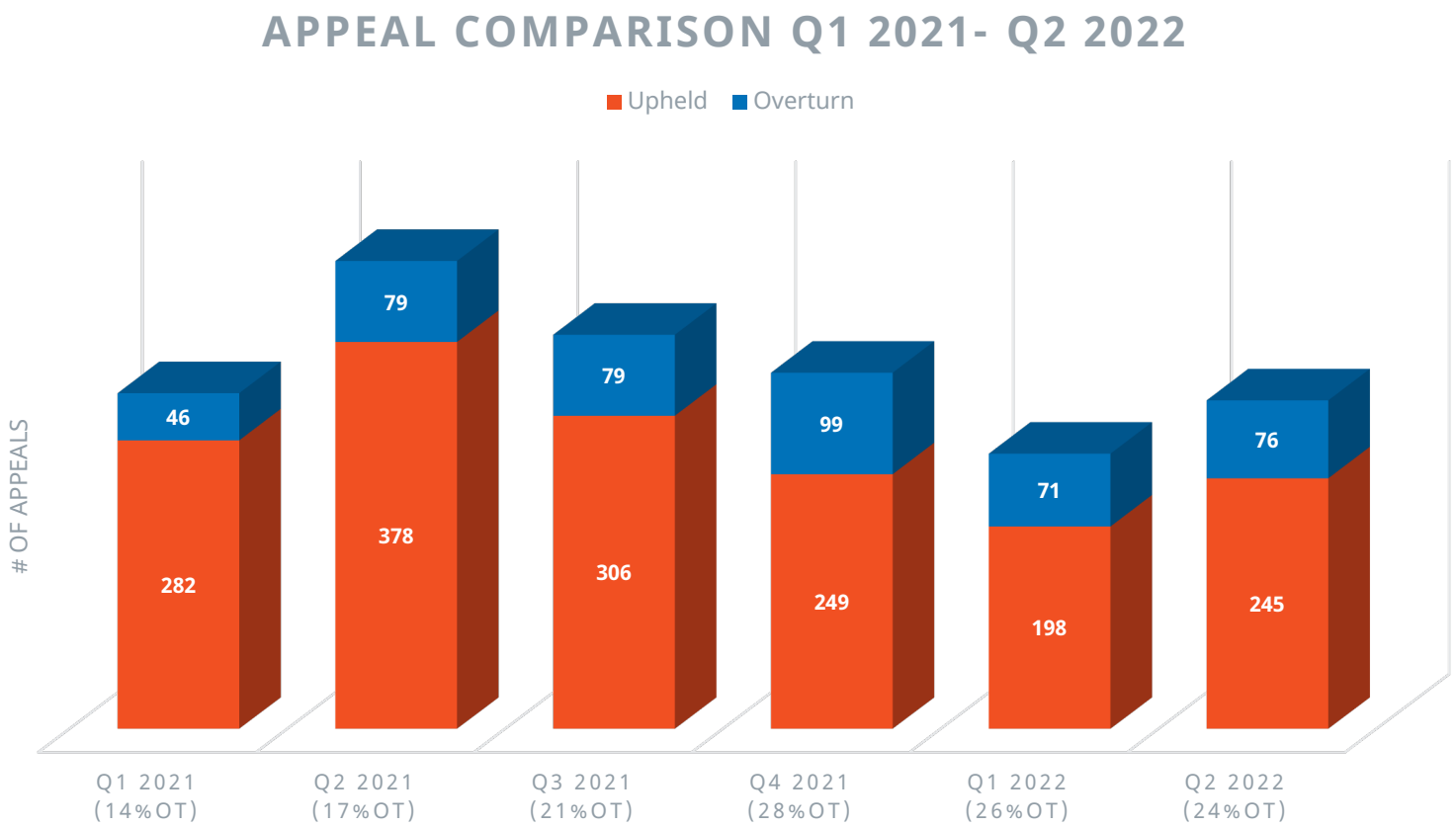
CalOptima Health

Appeals - All Lines of Business Q1 2021 – Q2 2022



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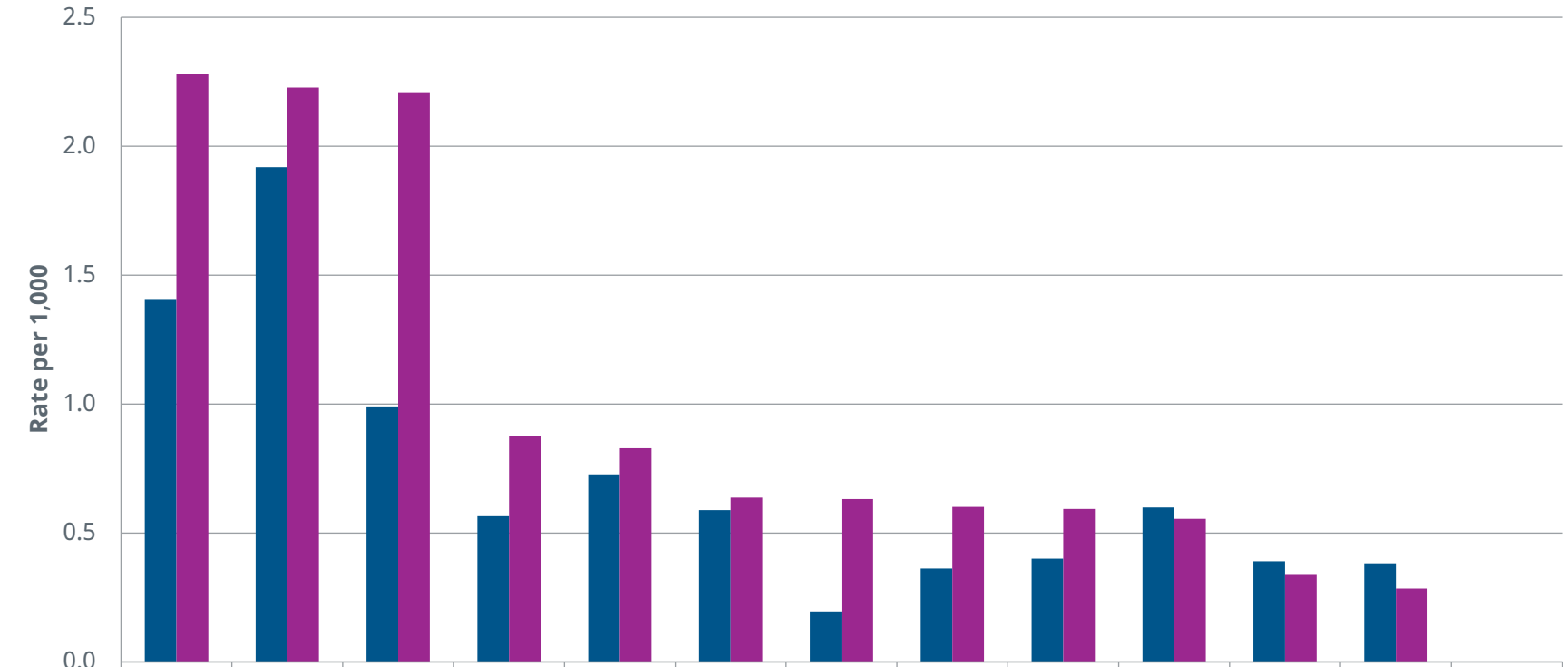
CalOptima Health

Medi-Cal Member Appeals Rate per 1000



	CCN (109,735)	Monarch (97,220)	Heritage (8,184)	Arta (64,515)	Kaiser (55,742)	CHA (158,450)	Prospect (41,362)	AltaMed (55,948)	Talbert (30,588)	Family Choice (47,373)	UCMG (41,510)	Noble (21,203)	AMVI (27,234)
Q1-22 ()	1.40	1.92	0.99	0.57	0.73	0.59	0.20	0.36	0.40	0.60	0.39	0.38	0.00
Q2-22 ()	2.28	2.23	2.21	0.87	0.83	0.64	0.63	0.60	0.59	0.55	0.34	0.28	0.00

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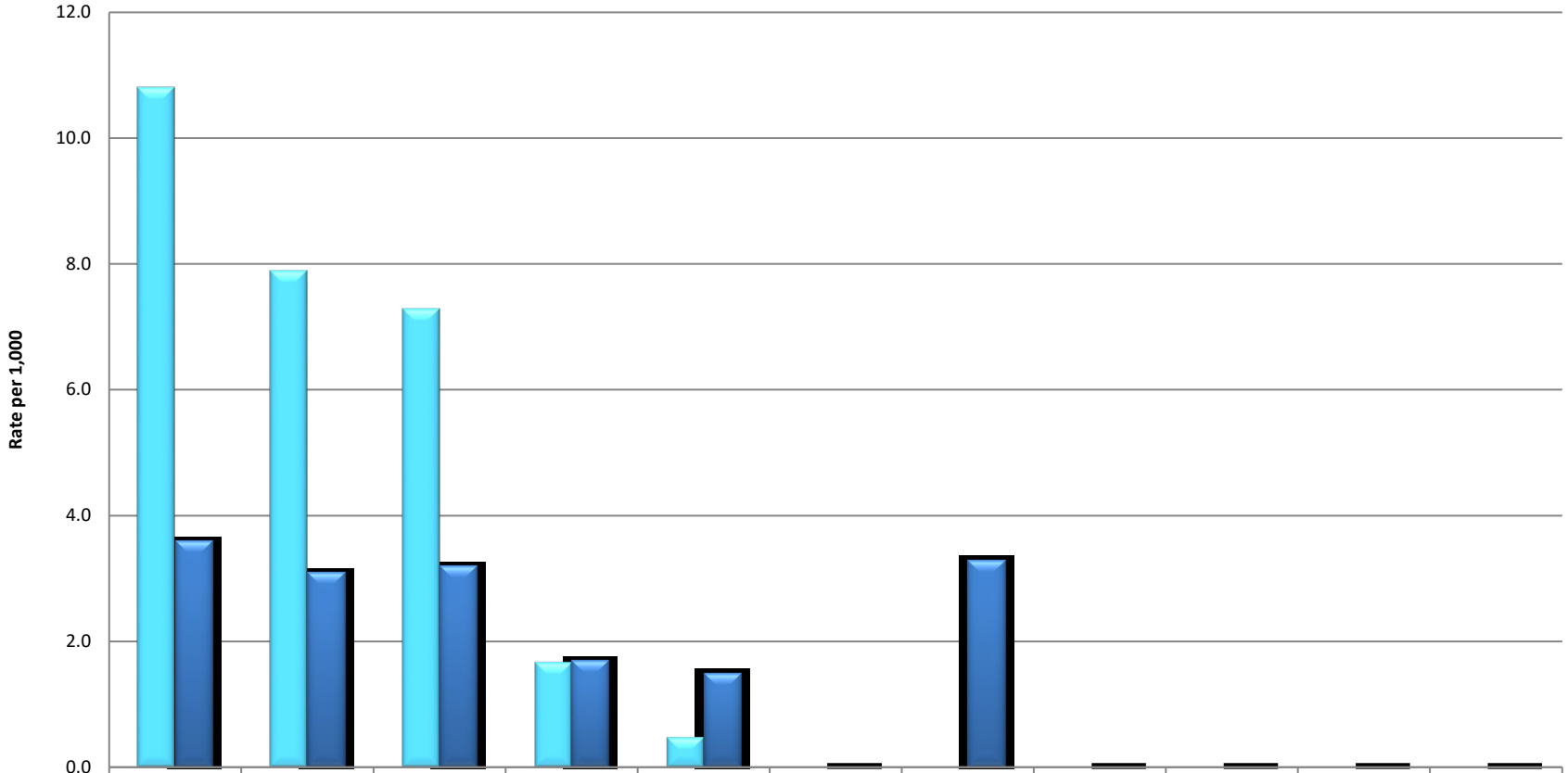
Medi-Cal
CalOptima Health

OCC Member Appeals
Rate per 1000



	Monarch (4,523)	Alta Med Health (629)	CCN (2,195)	Talbert (1,162)	Prospect (2,028)	AMVI Care (386)	Arta (618)	Family Choice (1,868)	Heritage (207)	Noble (357)	UCMG (619)
Q1-22 ()	10.8	7.9	7.3	1.7	0.5	0.0	0.0	0.0	0.0	0.0	0.0
Q2-22 ()	3.6	3.1	3.2	1.7	1.5	0.0	3.3	0.0	0.0	0.0	0.0

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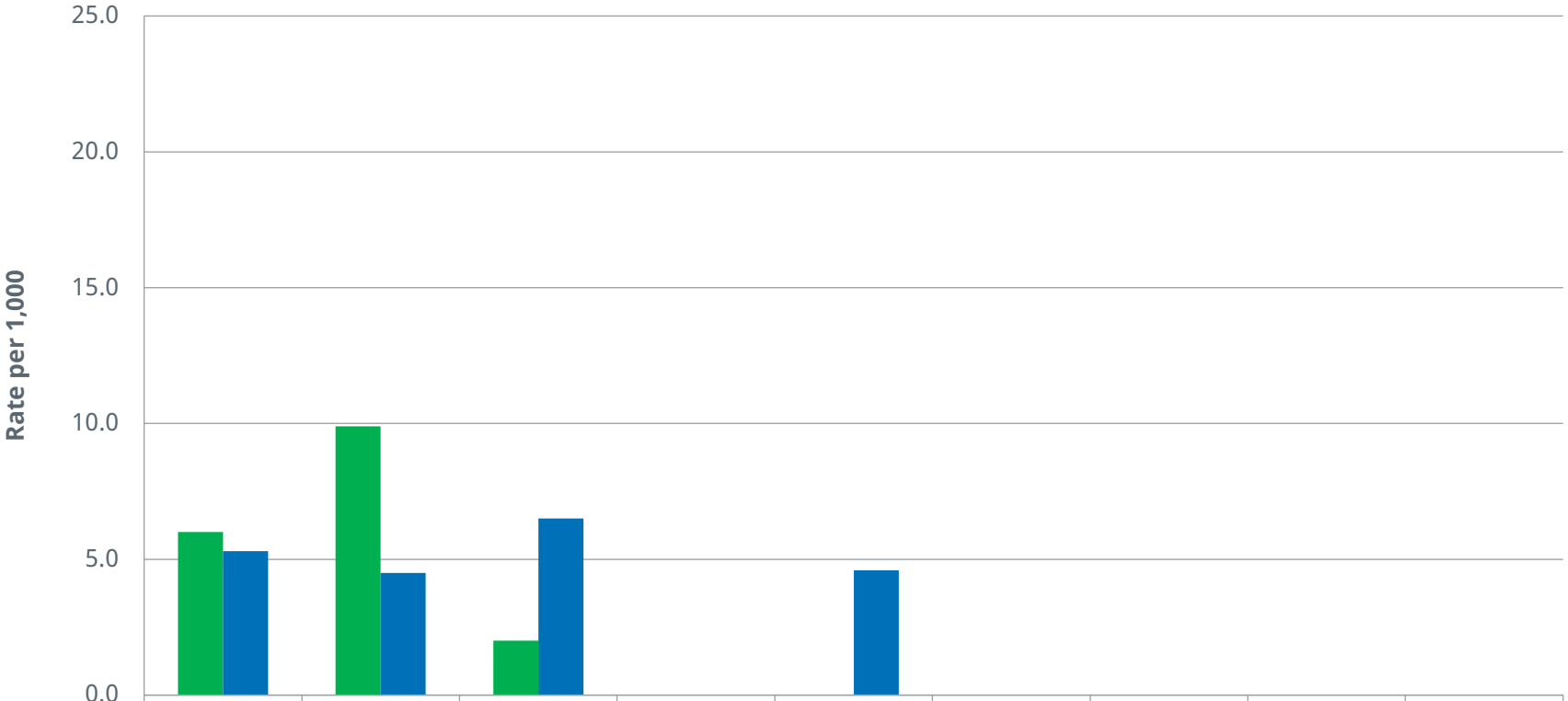
OneCare Member Appeals Rate per 1000



	Family Choice (167)	Alta Med Health (202)	Monarch (999)	OC Operations (2,390)	AMVI/ Prospect (412)	Arta Western (212)	Noble (31)	Talbert (242)	UCMG (126)
Q1-22 ()	6.0	9.9	2.0	0.0	0.0	0.0	0.0	0.0	0.0
Q2-22 ()	5.3	4.5	6.5	0.0	4.6	0.0	0.0	0.0	0.0

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